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HEALTH CARE REFORM

HEARING

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

ON

EXAMINING THE BATTLES FAMILIES AND BUSINESSES FACE IN THE COST OF HEALTH INSURANCE

APRIL 23, 1992 (DUNDALK, MD)

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HEALTH CARE REFORM

THURSDAY, APRIL 23, 1992

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Dundalk, MD.

The committee met, pursuant to notice, at 9:25 a.m., in the Roy Staten Building, Dundalk Community College, 7200 Sollers Point Road, Dundalk, MD, Senator Barbara A. Mikulski, presiding.

Present: Senator Mikulski.

OPENING STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. The Labor and Human Resources Committee field hearing on "Health Insurance Reform" will now officially come to order.

I want to thank you all for being here. On behalf of the U.S. Senate and as the Senator from Maryland, I am holding this hearing today because we are in a war for America's future. We are now fighting for jobs today and jobs tomorrow. And a very important component of those jobs is health insurance for those who are unemployed or underemployed or temporarily employed, who often find that health insurance is not available.

Both families and employers are finding health insurance to be very difficult in terms of its affordability, and everyone says that we need to contain cost, we need to contain greed, and we need to contain fraud.

As I have traveled throughout Maryland, I have heard the same concerns. People want fundamental change. People feel that health care and health insurance assistance in this country are hemorrhaging. They don't want bandaids to fix them. They want something that will really meet their needs. And again, whether I talk to high-tech business or high-touch volunteers, or families trying to meet their needs, they all say the same thing. They want reform—they don't want tinkering—and they want it now.

I wanted to hold this hearing because it is important for me to hear what Marylanders are facing. I don't believe that a United States Senator should only be talking to the gold letterhead crowd who can afford to come to Washington and hire lobbyists at $300 an hour to tell their stories. I want to hear from real families. I want to hear from business in Maryland. And I want to hear from the providers, those in Maryland who are absolutely committed to maintaining quality health care without shifting the costs to others and who want to contain costs without cutting quality.

Marylanders face some of the toughest problems with health insurance in the country. Maryland families are paying almost

$4,500 a year for health insurance. This makes Maryland the 10th-highest State in the country in health care costs.

Even though senior citizens have Medicare to cover hospital and doctor bills, they are still spending 15 percent of their income on health care needs. They often have to make choices between paying for their health insurance or making sure they aren't cutting back on utilities.

But the news is not all bad. In Maryland, we have begun to tackle some of those reforms. We have something called an all-payor system that contains hospital costs without cutting quality. The Maryland General Assembly has passed a "no frills" insurance policy that enables small business and individuals to afford health insurance. And third, Maryland is looking at comprehensive insurance reform.

I look forward to hearing from all of you because I believe that in Maryland, the people are my best advisors. And today I wanted to get the best advice.

I wanted to hold this hearing at Dundalk Community College. The Community College has always been a gateway to opportunity, and we are looking forward to hearing this testimony.

[The prepared statement of Senator Mikulski follows:]

PREPARED STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Thank you all for being here today. I am holding this hearing today because we are in a war for America's future. One of the battles families and businesses face in this war is the cost of health insurance.

As I have traveled throughout Maryland, I have heard the same concerns. People want fundamental change. they want far-reaching change. People feel that health care and health insurance systems in this country are hemorrhaging and they don't want band-aids to fix them. They want something that will really meet their needs.

Whether I talk to high-tech businesses or high-touch volunteers or families, they all say the same thing: They want reform and they want it now.

I wanted to hold this hearing because it is important to me to hear from you what should be done to change our health insurance system and make it work better.

Marylanders face some of the toughest problems with health insurance in the country. Maryland families are paying an average of almost $4,500 for health care every year. This makes Maryland the 10th highest State in the country in health care costs.

It costs Baltimore businesses almost $400 per worker per month for group health insurance.

Even though senior citizens have medicare to cover hospital and doctor bills, they are still spending more than 15 percent of their income on their health care needs. They often have to make impossible choices between health care, rent, and food.

But the news is not all bad. In Maryland, we have already begun to tackle some of the tough problems in health insurance reform.

First, we have an all-payor system for hospitals. That system has kept hospital costs down below the national average and has made hospital services available to people without insurance.

Second, Maryland has created a "bare-bones" policy that eliminates most State mandates to see if it can help small businesses and individuals afford health insurance. There have been mixed reviews of this plan, but Maryland should be given credit for trying to find new solutions to our health insurance problems.

Third, Maryland, is continuing to look at comprehensive reforms that can improve Marylanders' access to affordable health insurance.

There are many directions we can take to reform our current health care system. The types of reforms range from providing tax incentives and small business insurance reform all the way to a national health insurance system that includes long-term care.

I look forward to hearing from all of the witnesses today. There have been more than 40 proposals introduced in the Congress over the past 2 years on health insurance reform. This hearing will help me make some decisions about what I support in the Senate.

I look forward to everyone's testimony and moving this debate forward so that everyone in Maryland and in America can find affordable health care.

I'm now going to turn to our first panel and they'll tell you about themselves. But if the Allens would bear with me for a moment, we have Mrs. Donna Welsh, who lives here in the Dundalk-Holabird area. I became acquainted with Mrs. Welsh because I dialed a wrong number.

Every time I call my sister, I have a unique way of pushing the wrong first two digits, and I have met Mrs. Welsh through the telephone. I have never met Mrs. Welsh in person until this hearing today. But I believe that the Lord works in mysterious ways, and I believe that sometimes the wrong number is the right phone call.

In talking to Mrs. Welsh, I asked her about her health insurance situation—I like to just reach out to people and talk to them spontaneously—she told me her story, and I believe it is pretty typical of what many families are facing, and that is why I asked her to join us today. So it was a wrong number, but the right choice.

And of course, we have the Allen family, who are small business people form Montgomery County, and they have a particular story that they want to tell, and we are looking forward to that.

Now, Mrs. Welsh, would you like to start off, and then we will go to Karin and Elizabeth Allen.

STATEMENTS OF DONNA WELSH, DUNDALK, MD; ELIZABETH ALLEN, BETHESDA, MD; AND KARIN ALLEN, BETHESDA, MD

Mrs. WELSH. I am testifying at this hearing with the hope that new reforms will help people like my family to deal with the financial hardships that sometimes come when someone in the family has medical problems.

First of all, we are a middle-income family paying $48.78 a week for medical insurance. But all of our claims for medical equipment, except one, have been rejected. They have included batteries that cost $125; a battery charger that cost $130; a $450 charge for the installation of a stair glide; $2,300 for a lift in our yard, and $385 for a ramp for our van.

As you can see, this equipment is very expensive, and these prices do not include the maintenance and repair of the equipment.

Lower-income families have Medicaid. Upper-income families can handle this kind of expense. But where does the middle-income family turn?

Senator MIKULSKI. Mrs. Welsh, not to interrupt you, but do you want to tell us why you need batteries, a van, and a lift—just a little bit leading into why these issues are crucial, a little bit of a family portrait, if you don't mind.

Mrs. WELSH. Yes. My son has severe complex congenital heart disease, and as he grew older, he needed a scooter to get around and be like other children, be normal. And when the batteries broke down, we went to the medical company, of course, because we didn't know any other options existed. Batteries were $125 apiece. Then the charger went out; that was $130. We borrowed a stairglide from an organization called Volunteers for Medical Engineering, but we did have to pay $450 to have the stairglide installed so that he can get up and down the stairs, because now he is over 70 pounds. Before, it was very easy for us to carry him in and out of the house and up and down the stairs, but now it is getting more difficult as time goes on.

We have a lift in our yard, because I live right back here, and we are on a hill, and out front it is just impossible to get him in and out anymore. So now we have a lift in the back where he can bring his scooter in and charge the batteries every night.

Because they wouldn't pay for a ramp for our van, we had one made that was stainless steel by a welding company near us, to help us get him in and out. Then eventually, later on, I guess there will be a time when we will have to get an automatic lift because it is heavy, and it gets more difficult as time goes on.

But as he is getting older, he needs more equipment to get around and just lead a normal life.

Senator MIKULSKI. I interrupted you when you were going to tell us about when your husband discovered what the batteries cost.

Mrs. WELSH. OK. In March, we needed a new battery charger, and of course we went to the medical company that we bought the scooter from, and it was $130. About a month ago, accidentally, my husband met an engineer down at the North Point Recreation Center, and he suggested that he go to North Point Road to the battery warehouse, and there the batteries only cost $62. So the medical companies are making a pretty big profit themselves when you have to buy equipment from them.

Then on our income tax, because of the way it is written up, our expenses were almost $4,000, but because of our income we were only allowed a $625 deduction on our taxes for medical.

And last of all, an information network would be helpful where you can get information about organizations that lend out medical equipment, where to buy medical equipment at the most reasonable prices, and where if possible you can get financial assistance.

I hope that my testimony has given a better insight into some of the problems faced by people like my family. I also hope that new legislation will give everyone a chance to get good medical care and the medical equipment they need to live as normal a life as possible.

Senator MIKULSKI. Thank you very much, Mrs. Welsh. We'll come back and ask you some questions about your health insurance, what it paid for, and so on.

Let's turn now to the Allen family. We look forward to your testimony.

Ms. ALLEN. Senator, and members of the committee, my name is Elizabeth Allen, and I am here today to tell you about my present health insurance problems and to ask for your help in legislating some type of national health insurance for all Americans.

At age 28, I am forced to live with the results of 14 years of futile interventions to align my bite. In 1977, orthodontics attempted to close a simple overbite that I had, but the 2-year treatment left me with a serious malocclusion, or open bite, which created the onset of something called temporal mandibular joint dysfunction, better known as TMJ.

In 1983, after all conservative attempts to correct the malocclusion had failed, lower jaw surgery was performed. Unfortunately, this surgery only brought short-term relief as I suffered a relapse, and my bite progressively began to open up again beginning in 1985.

Seven years later, the pressure on my joints at this time has worn down my condyles to where only my third molars contact, and my joints now have severe arthritis. I have been advised by several well-respected specialists that I need treatment and surgery as soon as possible to minimize the pressure on my joints and proper bite alignment. At the present rate of bone erosion, the joint pain will become intolerable, and chewing will become difficult in the very, very near future.

Up until last month, I was receiving treatment—x rays, molds, et cetera—that were initiated by an admired oral surgeon right here at the University of Maryland at Baltimore. Unfortunately, all of this treatment came to an abrupt halt because my present health insurance carrier will not pay for any pre-existing medical conditions.

So here I am at 28, and I stand to lose everything that I have ever worked for. In my particular case, I once had group health insurance through a large organization, but I was laid off over a year ago. The COBRA for the HMO was unaffordable at over $160 a month. Today's economic atmosphere has forced me into full-time temporary assignments at another large corporation since July of 1981. This corporation, even though I am working 40 hours a week and many times over 40 hours a week, this corporation, like most, does not provide any medical benefits for temporaries. During this time I have bought two gap insurance policies each for about 6 months, just to get by in the event I have any type of car accident.

While these policies are affordable, at approximately $70 to $80 a month, they do not cover any pre-existing medical care, they do not cover any preventive care, and they have very large deductibles. All standard insurance policies I have attempted to obtain, whether they be through Blue Cross/Blue Shield, Prudential and many other carriers, are also very unaffordable for me. They have high premiums, high deductibles, and yet they do not cover any pre-existing conditions.

It is very difficult for me to adequately express my outrage about this health insurance situation. I believe Congress needs to begin legislating a health insurance program that is affordable coverage even for those people who are changing jobs, a program which encourages prevention and does not exclude medically necessary procedures, most of which are honestly pre-existing by nature.

Our current health care system is deteriorating at an alarming rate. Personally, working for a large organization, sometimes in their corporate benefits division, I know that there is a strong concern on how to keep costs down without sacrificing health care for their employees. The only suggested solutions that I personally have been hearing from the corporate offices are to continue to raise premiums and deductibles, deliver less care options, and increase the waiting periods. These options are only short-term bandages; they are not long-term solutions.

Canadians have continuous, affordable health insurance coverage even for those who are unemployed or even temporarily unemployed. Most European countries' health insurance programs have worked for several decades because the foundation of their systems are simple and streamlined. You don't have them wasting billions of dollars in paper-pushing every year. It is streamlined. It is under one roof. It makes sense. It makes a lot of sense.

I can only hope that our country adopts this type of universal health care coverage soon. My future health and millions of Americans' future health depend on it.

Thank you for this opportunity.

Senator MIKULSKI. Thank you, Ms. Allen.

Mrs. Karin Allen.

Mrs. ALLEN. Senator Mikulski, I thank you very much for the opportunity to speak to you this morning about my particular problem.

Like millions of Americans, I have "job lock" and "insurance lock" because of a pre-existing condition that was not my choice. I'd like you to hear what it feels like for someone in my position.

I have been labelled by the private health insurance industry as practically uninsurable because I have a back problem. I really believe that I would be a happier person if I lived in Canada or France or Germany, and please forgive me for being so blunt, but I really think that our present health insurance situation is unbearable, it is intolerable.

I work for a small business in a full-time position. In 1987, my employer bought major medical small group health insurance. This insurance policy promises a $1 million lifetime benefit for each member of the group. In 1987, there were three of us. My daughter was briefly included while she was in college. The original premiums were $325 for three subscribers. Unfortunately, in 1988 I needed back surgery, and Blue Cross and Blue Shield increased our premiums following my surgery to $750 a month.

I have attached to my testimony a copy of the letter from Blue Cross and Blue Shield that blames me personally, my $19,000 claim, for the rate increase and states very clearly that because of this one claim the entire group was labelled as a "high risk."

To me as a health insurance consumer, it feels terrible—that's all I can say—to be paying for this.

In the meantime, I have been turned down for coverage by over one dozen insurance companies because of my ongoing back problem. Among them were Cigna, Prudential, Kaiser Permanente, Group Health, Alliance for Small Business, American Small Business Association, and Bankers' Life Insurance Company. There have been others that I can't even remember that have called our small business—oh, yes, the last one, Mutual of Omaha, a Mr. Ralph Ederesio, called and said, "Is everyone healthy?"

And I told him, "I'm sorry. No. I have a problem."

Anyway, I really feel that if my daughter and I lived in Canada we would not suffer these perpetual anxieties about health insurance. And while the rest of the world basically has national health care, Americans unfortunately face the humiliating practice of medical underwriting, high deductibles and copayments, all of which I really believe are powerful deterrents to getting proper health insurance, and I believe even though maybe in those other countries, the health insurance is taken over through taxes, they are eliminating the copayments and deductibles, basically out-of-pocket costs, and they are replacing it with a tax, which in my case I really feel is more fair because it takes the income of that person into consideration.

In my particular case, there is absolutely no relationship between my income and my health insurance premium. My employer presently pays $443 a month for my single coverage, which represents to my employer a 35 percent payroll tax, and over 50 percent of my take-home pay, Senator Mikulski.

My employer for one would welcome an 8, and even a 10 percent payroll tax——

Senator MIKULSKI. Do you want to repeat that last point, Mrs. Allen, about your take-home pay?

Mrs. ALLEN. My health insurance premium, the $443 a month, which I am locked into because no other insurance company will cover me, represents a 35 percent payroll tax to my employer and is over 50 percent of my take-home pay. It is extraordinary. If this were replaced with a payroll tax of 8 percent, I think my premium would drop down to about $95 a month, which would be fair; I feel that's the way we really need to go in this country.

I'd just like to add that our insurance company now uses strict medical underwriting for new employees and their dependents. The health questionnaire that I brought with me, on the second page has 14 questions. These 14 questions cover over 40 medical conditions. And if you answer "yes" to one of those questions, you may not get coverage through our insurance company.

I have a map here, and I'd like to tell you that because I was so frustrated as an individual and as a citizen, I wanted to know what people who lived around me and my friends were feeling about the health insurance problem. I got together a petition. We live in a middle-class suburb in a neighborhood with about 585 homes, and I gradually wound myself from street to street, explaining the situation and asking my neighbors how they feel. And it is amazing—to date I have come face-to-face with about 180 of those homeowners, and over 90 percent of these homeowners—the ones that are pencilled in in yellow—support a universal health insur-

ance program for all Americans, because that's what my petition said, which I drafted up on my own.

The response I'm getting is phenomenal. You have no idea how fed up people are. People are so upset about their own health insurance situation and that of their children or grandchildren. And really, I just cannot emphasize strongly enough the point of how serious the situation is for someone like me who is locked in. I can't get insurance, and the insurance company is never going to let me forget that I have a back problem. I can't ever put it behind me because I am reminded with these health questionnaires constantly, on the phone. "Do you have a pre-existing condition?" "Yes." "What is it?" Now I'm just beginning to hang up. I just can't deal with it anymore.

I thank you.

[The prepared statement of Mrs. Allen appears in the appendix.]

Senator MIKULSKI. Thank you very much, Mrs. Allen. I think that was very impassioned testimony. What you are saying is that there is an urgency.

Mrs. Welsh, what is your son's name?

Mrs. WELSH. Darryl.

Senator MIKULSKI. Darryl is not going to get younger. Darryl is going to get older, Darryl is going to get heavier, and congestive heart disease is a situation that is chronic for Darryl. And it is therefore a chronic health insurance system for the Welsh family as well as for this young man, ultimately, coming from a loving home and a school system that is trying to meet his needs, which will make it difficult for him to find employment.

Let me ask you a question, Mrs. Welsh, and then go to the Allen family. Where does your husband work?

Mrs. WELSH. The Sun papers.

Senator MIKULSKI. And you have health insurance through his employment?

Mrs. WELSH. Right.

Senator MIKULSKI. So are the family's needs met through that health insurance?

Mrs. WELSH. They have several HMO plans, and we're with Blue Cross and Blue Shield. We have to take the best and pay the premium because when Darryl goes for his checkups once every 6 months, he goes to Hopkins, and the tests they take are very expensive. If we didn't have that plan, the tests would not be covered.

But as far as medical equipment is concerned, they don't touch it.

Senator MIKULSKI. So in your case, the premium that you must go for is what is normally called a "high option" type, which includes more and complex benefits.

Mrs. WELSH. Right.

Senator MIKULSKI. And you have a copayment and a deductible?

Mrs. WELSH. Yes. Our deductible is $200 for a family, $100 for each individual.

Senator MIKULSKI. So in your case, both your family's needs and then Darryl's medical needs are being covered by the insurance program.

Mrs. WELSH. For the most part, yes.

Senator MIKULSKI. For the most part. What you don't have is the insurance for a family where there is a condition that requires medical equipment. And what you are saying is that medical equipment is a whole different situation.

Mrs. WELSH. Right.

Senator MIKULSKI. But these wonderful technological breakthroughs that enable your son to be with you—a stairglide, a van, so he can go to ball games and picnics and so on—all of those things are available technologically, but they are not affordable, or they are not covered.

Mrs. WELSH. Right. They don't consider those a necessary part of his life.

Senator MIKULSKI. How old is Darryl?

Mrs. WELSH. Eleven.

Senator MIKULSKI. And I'll bet his body heart is one way, but I'll bet his spirit heart is spunky; am I correct?

Mrs. WELSH. Right.

Senator MIKULSKI. And again, the technology, like the scooter, enables him to zip around the neighborhood.

Mrs. WELSH. With the other kids, sure.

Senator MIKULSKI. So the medical equipment is a lifeline, but because it is not oxygen—it's his lifeline to just being able to——

Mrs. WELSH. To be able to get out and have a good time.

Senator MIKULSKI [continuing]. But even being able to go to school and move around and do these other things.

Mrs. WELSH. Yes. He needs the scooter for school.

Senator MIKULSKI. And otherwise it would be very difficult for him to go to school.

Mrs. WELSH. Right. He couldn't walk. The school, Holabird Middle, is all on one floor, but it is so spread out that he could not walk that far to get from one class to another, so he does use the scooter.

Senator MIKULSKI. I see. Now, if your husband were to change jobs, what do you think would happen?

Mrs. WELSH. Gee, I couldn't imagine.

Senator MIKULSKI. And you are a full-time homemaker?

Mrs. WELSH. Right.

Senator MIKULSKI. Because again, Darryl's care requires you to——

Mrs. WELSH. To be home full-time, because if I had a job, I couldn't come to you and say I'll be out 2 or 3 or 4 weeks because my son is sick. You just can't do that.

Senator MIKULSKI. Which is another whole cost to families and to the caregiver.

Mrs. WELSH. Sure. We're a one-income family.

Senator MIKULSKI. But the thought is, based on the Allens and what I think we'll hear from others, that it will be very difficult, and Darryl will face in his future—I'm sure you have wonderful plans for him.

Do you have other children?

Mrs. WELSH. No.

Senator MIKULSKI. But I'm sure you have wonderful plans for Darryl, and because of medical technology he would have a future,

but it's going to be tough for him because, like Mrs. Allen said, she is always going to have her back problem.

Mrs. WELSH. That's right.

Senator MIKULSKI. Thank you.

Mrs. Allen, both of you have talked about the European plans which are done through the government, and it was very informative. You should know that right now there are 30 different plans pending before the United States Congress on health insurance reform. They range from simply tax breaks—which doesn't necessarily change the system—to the single-payer system, which is based on the Canadian model, and then to something called "pay or play" which is based on the German model.

I believe that Congress should pass one of these even for the national debate, particularly either "pay or play" or single-payer, by July—at least move it. And we are trying to get ideas as to what are the best directions, and I have a feeling it will be the best elements of both.

But if I could go to you, Elizabeth, you are a temporary employee. May I ask your educational background and what is your field of expertise?

Ms. ALLEN. I have a bachelor of science in journalism with a double major in management, and an associate degree in marketing. The company that I am now working for temporarily on a full-time basis, because they aren't really hiring any management at this time, I have been with them off and on since 1981. So I have been there from right after I put myself through college and started working.

Senator MIKULSKI. Do you feel that when you would apply for a job at, say, a Pulitzer Prize-winning magazine or newspaper or whatever that your condition would give an employer pause to hire you?

Ms. ALLEN. Well, luckily for myself, until I became unemployed when I was laid off, I was lucky enough to get into large companies where you didn't have to fill out long documentation. It was never an issue at that point. I was very, very lucky before. It is only now, trying to go out on my own and get my own insurance, that it is terrible. Even the insurance that the company, the large organization that I work with has, if I were to work permanently on a full-time basis, they don't cover anything. In fact, I spoke with the particular carrier that they go through, and they told me that most likely they would do a permanent underwritten exclusion of anything having to do with my mouth at all.

And this is a complication that is through no fault of my own at all.

Senator MIKULSKI. It's not behavioral or lifestyle. It is structural.

Ms. ALLEN. Basically, yes.

Senator MIKULSKI. Mrs. Allen, do you feel that you could change jobs? You said you had "job lock."

Mrs. ALLEN. Yes, because my employer is going to be retiring soon, and because the job situation is very poor right now. I have seen Elizabeth send out over 200 resumes, and she hasn't found anything. And I am over 50, and I don't have a strong educational background. I just took some courses at Montgomery College. So I am fearful that I would most likely wind up in a retail position in

some large department store, but for me that would be prohibitive because of my back problems. Standing for 2 hours would be very, very difficult, and that's the situation I would be in.

I am really afraid that some of the small companies that we are dealing with with interior designers don't have their health insurance policies—they are fortunate to get health insurance and keep theirs. I have two designers right now that I work with, that I see almost weekly, who have dropped their health insurance because they could no longer afford it because they have to shop. And even though the Association of Interior Designers, I understand it is now very difficult to get in. One of our designers tried to get health insurance and stopped midway because the health questions were so severe. So she is just sticking with what she has now, which is Prudential, which is around $400 a month, and she is afraid she won't find other health insurance if she ever drops that.

I am just not confident with what I read in the paper and I have seen on the news, with people being excluded, and this has now been front-page articles in the New York Times and the Washington Post, that I would find a job that would cover my back problem. It might be excluded.

Senator MIKULSKI. I understand. I think what we have heard from you is what pre-existing conditions, medical or structural, mean in terms of that, and also the impact on an employer.

In Ms. Allen's case, both the economy and her condition converged to make it difficult for her to practice her craft, and for you, Mrs. Allen, you have had an employer who has obviously stuck by you and made a major effort, but for many, because of the circumstances of their own business or their own views of the world, would not necessarily have done that.

Mrs. ALLEN. If I may just mention this, because I really think it is very important, we have tried to get group health insurance through a large association, the Maryland State Floor Covering Association. I contacted them, and they sent us a small group screening, and again there were questions on that—have you spent over $5,000 on medical bills in the past 12 months, or is it anticipated that you might need further surgery—and I had to answer "yes" to that. And I was told by a Mr. Mervin there—and this was for MDIPA, this was for an HMO through a large trade association—that they could "not accept me into their insurance trust." And now I won't try anymore.

Senator MIKULSKI. I understand. Even the language that we use—Elizabeth, you used words like "under COBRA," or "I was under an HMO when the MDIPA got me into this and that"—for most people, it's difficult even to be able to understand.

Ms. ALLEN. It has been a nightmare. The whole thing has been an absolute nightmare. At this point right now, I am trying desperately to get into the study at NIH, but because I have already had surgery, I don't meet their protocol. I am really in a pickle, so to speak. I have no avenues at this point.

I'm a very healthy 28-year-old. Everything else is perfect. But I can't even afford to go to a doctor at this point because the deductible is so high on my policy, which covers practically nothing, no preventative care. I can't even go just to get a regular physical, with a $500 deductible.

Senator MIKULSKI. We're going to have to move on now to our next panel. We appreciate your candor and your willingness to come. I'll tell you what we're going to do. Our next panel will be senior citizens and their unique needs, and then we have asked people associated with insurance to testify. So you are welcome if you'd like to stay, and we thank you. This has given both me and the committee insights that we did not have.

Like you said, this sure shouldn't be happening in the United States of America, and obviously, people who want to practice self-help and self-reliance.

Thank you.

We're now going to turn to our panel of senior citizens, and I'll ask them to come forward. We welcome the AARP, the Gray Panthers, the National Association of Retired Federal Employees, and the National Council of Senior Citizens.

Good morning. We know that seniors have their own particular health care needs, particularly long-term care, the ever-increasing cost of prescription drugs, and while seniors have Medicare, which was enacted in 1965 to cover many health care costs like hospital and doctor bills, seniors still spend that 15 percent of their income.

We look forward to hearing your testimony. In my own case, with my father who had Alzheimer's, I know the difficulty of determining what was covered and what was not as we looked for geriatric evaluation, adult day care, and all of those things necessary. And recently I had a "town hall" meeting with the Canton senior citizens, and they emphasized the need for prescription drugs and that this is an enormous problem.

So we look forward to anything you have to tell us as well as what you think should be the direction we should go in with these 30 different ideas that are floating around Congress.

Let's hear from you first, Mr. Bloom. You represent the Gray Panthers of Maryland, and are from Silver Spring.

STATEMENTS OF ABE BLOOM, GRAY PANTHERS OF MONTGOMERY COUNTY, SILVER SPRING, MD; MARTIN WISH, NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES, SILVER SPRING, MD; JOHN LAWNICZAK, NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON, DC; FREDERICK F. OTTO, CHAIRMAN, MARYLAND STATE LEGISLATIVE COMMITTEE OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS, HAGERSTOWN, MD

Mr. BLOOM. Senator, I am Abe Bloom, and I speak for the Gray Panthers of Maryland. We are committed to advocate for a national health plan based on a single-payer system. Our National Health Committee has asked me to convey a special message to you. We believe it is important that you should know that I and all in our Maryland chapter are volunteers. As an organization, we do not contribute to political campaigns, we hire no paid lobbyists and pay no honorariums, we are not a special-interest group. Our activity is based on the principle that health care is a basic human right.

We hope that this hearing shows that you want to hear from us ordinary people—and I have heard you say that. We do not try to match the money interests, but we know that we speak for the people who are suffering from the failures of this country's health care

nonsystem. The failures of our nonsystem show themselves in many ways.

There is a crisis for the elderly. There is a crisis for the poor. For the elderly, Medicare has failed. For the poor, Medicaid has failed. We can go into those failures if you wish to ask further on that.

For all the others, there is a crisis because of a lack of access and an unwarranted escalation of costs. Not only are our costs too high, but they are continuing to escalate and are estimated to rise from 12 percent of GNP today to 17.5 percent in the year 2000.

This is neglect of prevention. For instance, Maryland has the highest cancer rate of any of the 50 States. To rectify this, we must develop effective programs to reduce smoking, alcohol consumption, and to clean up our environment.

What is to be done? We recommend support for the single-payer plan in Senate Bill S. 2320 introduced by Senator Wellstone and cosponsored by Senators Simon and Metzenbaum. It provides a comprehensive package of benefits including hospital and physician care, long-term care, prescription drugs, preventive care and mental health benefits. Everyone would be covered and would only have to present their health card to the provider of their choice to receive treatment. The Federal Government would be the single payer, but the program would be administered by the States.

The plan would contain costs. The General Accounting Office has estimated that the adoption of a single-payer system in the United States would save $67 billion a year in administrative costs alone, more than enough to pay for the coverage of all the uninsured.

In addition to these administrative savings, because the Federal Government is the sole payer, it is in a strong position to contain costs through negotiated prices on prescription drugs, negotiated physician fees, global budgets for hospitals, and control of capital expenditures.

This plan overall will not cost more money. There will be new taxes, and these taxes will go into a dedicated trust fund that can be used for health purposes only. There will be new taxes, but less private spending on insurance and out-of-pocket costs. The net cost for most people will be less. For instance, a family of four with income of $39,200 will save $1,600.

We must respond to some of the horror stories that have been spread by the AMA, the insurance companies and the Bush Administration about the Canadian single-payer system. They say that people must put up with long waiting lines to get necessary treatment. These stories are untrue.

The reports we get from Canadian doctors are that in fact Canadians are availing themselves more of services than people here in the United States. There is more preventive care, which avoids later more serious and expensive illnesses.

We have the advantage in this country that our health care expenditures are at a higher level, 12 percent of GNP versus 8.6 percent for Canada, and we have much high-tech equipment already in place. Since there are no plans to cut these expenditures or facilities, we could in this country supply even better services, not fewer.

Polls show that the Canadians are more satisfied with their health care system than citizens in any other country. Similar polls

show that U.S. citizens are least satisfied. Here in the United States, we have 37 million uninsured who would just love to get on the Canadian waiting lines.

Compared to the single-payer plan, we find that the "pay or play" proposal introduced by Senator Mitchell as S. 1227 would set up a very inferior system. S. 1227 mandates that employers provide health benefits for their workers or pay a tax into a public fund that would be used to provide insurance for all those not covered on their jobs.

The major defect of this plan is its heavy dependence on private insurance with its high administrative costs, high marketing costs, and high profit margins. Their benefit payout averages 60 cents on the dollar compared to public systems like Social Security and Medicare which have benefit payouts of 98 cents on the dollar.

Insurance companies cannot be controlled because they are exempt from antitrust laws and are regulated on a State level with 50 different sets of State regulations. S. 1227 has tried to prevent some of the worst abuses such as the refusal of coverage for people with previous health conditions, but there are so many other abuses.

There are other problems with S. 1227. Many small businesses cannot afford the mandated coverage or the added tax imposed. For them, it can lead to business failures.

It has no provision for long-term care.

There will be an administrative nightmare to keep track of workers who change jobs and have to change insurers and providers, or those who become unemployed and must switch from the private to the public plan.

For the elderly who are covered by Medicare, S. 1227 will be of no help. They continue on Medicare with all its deficiencies.

Real cost containment will be sacrificed because the strength of a strong Federal Government negotiator will be lost.

The deficiencies of "pay or play" compared to the single-payer plan are obvious. The insurance companies should not be allowed to hold the American people hostage to an inferior program.

While we can understand why Senator Mikulski may want to support the Democratic Party leadership by support of S. 1227, we believe that she should recognize the superiority of S. 2320 and also become a cosponsor of that bill. Senator Wellstone has done just that.

We urge you, Senator Mikulski, to become a cosponsor of S. 2320.

[The prepared statement of Mr. Bloom appears in the appendix.]

Senator MIKULSKI. Thank you very much, Mr. Bloom, for that really informative statement and outline of the bill.

Just by way of comment—and then we'll go on to Mr. Wish, representing the Federal employees—the Kennedy committee on which I sit has moved the so-called "pay or play" bill. The reason for moving it was to advocate the debate. I think what we heard from our previous testifiers as well as yourself is that there doesn't seem to be the kind of urgency in the Congress that the American people feel. So our committee said let's take an idea and move it forward at least to get a reaction and get the debate going. So we are trying to move this debate. And know that my commitment is to the people of Maryland and the best system. My particular advo-

cacy of an individual bill at that time was to promote the debate. I have some problems with it, too, but we'll come back and have a conversation.

Mr. BLOOM. I'd like to discuss the single-payer idea with you further.

Senator MIKULSKI. Next let's go to Mr. Martin Wish, representing the National Association of Retired Federal Employees.

Mr. Wish, we give you a cordial welcome.

Mr. WISH. Thank you, Senator.

I am the immediate past president and director for Federal legislation for the Maryland Federation of Chapters of NARFE, the National Association of Retired Federal Employees.

There are over 110,000 Federal retirees and survivor annuitants in Maryland. We have 35 chapters throughout the State, with a total of about 24,000 members. We very much appreciate the opportunity to share our views with this committee.

With health care reform becoming a national issue second only to the economy, as an organization, as Federal retirees, and as concerned citizens, we are giving serious thought to where we stand on this important issue. Our membership has been asked to discuss and debate this issue thoroughly in preparation for our 1992 national convention in September.

In order to determine where we stand on the various proposals that have been offered thus far, we need to first consider why the problem has suddenly come to the front burner, and second, what are some of the critical considerations for the membership we represent and seniors in general.

What are the problems? First and foremost is the recognition that 32 to 37 million of our fellow citizens do not have coverage. As concerned Americans, we feel this situation is intolerable and must be addressed.

Health care costs are out of control and out of reach for millions of Americans. We now spend $700 billion—I have heard $800 billion recently—for health care, and we aren't getting full value for these vast sums.

Drug prices have increased an incredible 152 percent between 1980 and 1990. We are now caught in a vicious circle which forces all of us to pay more and more for less and less coverage. We spend more per person on health care than does any other Nation, yet millions have little or no access to adequate care, and others go without proper long-term care or become pauperized in the process.

Now, what are some of the critical considerations?

Federal retirees, survivor annuitants and Federal employees now essentially have good health benefits coverage—except for affordable long-term care. This is particularly true for those of us with Medicare coverage. If I may just digress, as a Federal retiree, I have FEHB, and I have Medicare. I have had in the last 3 years or less three surgeries. For those three surgeries under our system, I have paid less than $50 total in additional expenses.

So our system, FEHB and Medicare together, is excellent. However, there have been increased costs, and there is some need for fine-tuning of the Federal Employees Health Benefits System that has served us well. And the Congress is under the same system if I remember correctly.

The major gap in our present coverage is affordable long-term care. While long-term care has been perceived as an elderly issue, it is important to understand that 43 percent of all long-term care users are under age 65. In a recent survey, when asked if they had adequate insurance or other sources of money to pay for long-term care, 77 percent said no.

I just want to add here—it's not in my written testimony—something about long-term care. I know of your interest, Senator, and what you have already accomplished in that area. One in every two women and one in every three men 65 or older will spend some time in a nursing home. One in four will spend more than a year. Approximately 2.5 million Alzheimer's patients will need to be institutionalized. The average cost for nursing homes in this area is over $36,000 a year. Half of the elderly living alone, by themselves, would spend themselves into poverty after just 13 weeks in a nursing home. And according to "Families U.S.A.," 85 percent of older Americans cannot afford long-term care insurance premiums; two-thirds cannot even afford the lowest-priced nursing home care.

So, Senator, the issue of affordable long-term care must be addressed and cannot be deferred, and there are proposals before the Congress now that do not include it. We as an organization cannot support any proposal that will not include an affordable long-term care component.

I have brought with me and given to your staff petitions from 2,000 of your constituents. These are only from those we were able to reach. This is a long-term care campaign, and what these petitions say—and I won't read the whole thing—is that because long-term care is not covered by Medicare and most health insurance, because millions of American families must face the prospect of having their life savings wiped out by long-term care needs of a parent or child or spouse, we support legislation for long-term care protection for all American families that is comprehensive, includes both skilled and custodial care, and is universal.

Another critical consideration is that any changes that would have the potential for rationing health care or interfering with the timely delivery of health care would be unacceptable.

The following are some of the elements that we look for in any proposals that we would ultimately support. Do the proposed changes control costs? Do they include long-term care with broad-based financing to spread the risks? Do they keep financing of an improved system at reasonable levels? Do they seek to preserve the essence of our Federal Employee Health Benefits Program while promoting ways to reduce costs through greater efficiencies, or at a minimum, retain the existing level of benefits? Do they cover all Americans irrespective of job status, income level, pre-existing conditions, or age? And do they ensure quality health care based on universal applicability of the best technology and medical expertise?

While there are a myriad of proposals on the table at present and more surface each day, at this stage we are not prepared to support any specific proposal. We recognize the urgency of dealing with the need for providing coverage for the uninsured and for some action on cost containment. With respect to overall reform, however, we feel that it is extremely important to resist a rush to

judgment without full consideration of all the potential ramifications.

Thank you, Senator.

Senator MIKULSKI. Thank you very much, Mr. Wish. I know that the Federal employees have very good coverage, and of course now there is also an increasing Medicare linkage to it. But I also remember the disaster during the catastrophic debate in which the Federal employees were going to potentially pay double for the same coverage. And although Ms. Morella and I tried to change it, it was a poor idea to begin with. But my point is that as this debate moves on, we will absolutely be in consultation with the Federal employees, because I believe if it's not broke, don't try to fix it. Let's try to fix what needs to be fixed, and I think you and Mr. Bloom have outlined some of those problems.

I just want to note that Dr. Otto is not here, which is so uncharacteristic of him; I'm sure that there has been an unanticipated problem. The AARP testimony will be included in the record, and we will so notify Dr. Otto, and he might be coming in.

Let's next hear from the National Council of Senior Citizens.

Mr. LAWNICZAK. Good morning, Senator. My name is John Lawniczak, and it is a pleasure to be here. I represent the National Council of Senior Citizens. I am also here on behalf of our State affiliate, the Maryland State Council of Senior Citizens.

Since Mr. Bloom and Mr. Wish so ably gave my testimony already, I would basically like to just summarize the remarks and hopefully have the rest included in the record if I may.

Senator MIKULSKI. Yes, it will be included in full.

Mr. LAWNICZAK. We all know that our health system is in crisis. You heard earlier this morning from some people who were having some specific problems. But one thing that a lot of people do not realize is that retirees are also affected by the problem. Most people think that seniors who are supposed to be insulated through the Medicare program are doing well in today's system, but unfortunately they are feeling the squeeze with the rest of the population.

A lot of the problem is that Medicare leaves a lot of gaps in the program, and these gaps are generally covered by supplemental insurance policies which are earned sometimes as a benefit while they are working. These retirees depend on these benefits to cover these gaps, and unfortunately a lot of businesses are now starting to trim back on Medigap insurance coverage. According to the Employee Benefit Research Institute, over 50 percent of retirees receive their Medigap coverage from their former employers. These benefits are increasingly at risk. As a recent EBRI survey indicated, 5 percent of employers that offer retiree plans intend to drop coverage entirely within the next year, while 10 percent expect to reduce the benefits or increase the cost-sharing. Over 30 percent plan to increase deductibles and co-insurance that are required to maintain the program, and these numbers will only increase as the new accounting standards which were issued by the Financial Accounting Standards Board go into full effect.

As you know, in January 1993, employers for the first time will have to list as a liability any unfunded promises to provide health insurance for their retirees. Not only will businesses have to in-

clude their current retirees, but they will also have to include the over 11 million current workers who are promised some kind of health benefit after retirement.

An example of this is that General Motors recently put a $24 billion liability on their books to count all their future retirees and current retiree health programs. This, of course, lowers their bond rating to suddenly have a large liability put on their books and lowers their stock prices, making the company less viable.

However, equally alarming to us is the disastrous effect that bankruptcies and plant closings are having on retiree health benefits. Also of concern, actually, is the trade policy. When a company goes bankrupt or moves their plant or closes their plant, they often take their retiree health benefits with them. For example, when Pan Am went bankrupt, they had 20,000 retirees who instantly lost their health retirement benefits. When General Motors was in the process of laying off 74,000 people, these people, at least the older workers, have to choose between taking a lower pension rate and having their health care benefits paid for or taking a full pension without health care benefits at all. As you know, Medicare starts at the age of 65, so if you end up being forced out of work at age 55, then unfortunately in today's society, it is awfully difficult for someone 55 or older to find work, and you are essentially without health insurance for at least a decade.

The trade problem is the same; as plants move to other countries, they also take their retiree health benefits with them. We find that as we lose jobs, we are losing health benefits since health benefits are so closely tied to the work force.

The National Council of Senior Citizens has a defined position on national health care which we have honed over the years. Rather than develop a specific legislative proposal, we have constructed a set of 10 principles by which we endeavor to evaluate health reform legislation. These principles are in our testimony and we would urge you to look at them to help your own evaluation of any legislation that comes before Congress.

We have utilized these principles to evaluate the legislation before this committee and before Congress. While many bills meet at least some of these principles, such as comprehensive benefits, strong cost containment, and feasible and efficient administration, we find that most of them fall by the wayside for the lack of a long-term care program. Like Mr. Bloom and Mr. Wish, we will not support any legislation that does not include a long-term care provision.

Our examination of all these bills leads us to the finding that H.R. 1300 and S. 2320, introduced by Congressman Russo and Senator Wellstone, come closest to meeting the intent of our principles and promise a sound framework on which to provide comprehensive and efficient services under conditions that would enhance quality of care for all citizens. We believe that this bill will provide an effective control of escalating health costs. While it is not perfect, it goes a long way toward meeting all our goals.

It is our experience that the most sound public programs enacted are those which are inclusive by intent and design. Medicare and Social Security are a good example. Everyone pays in; everyone gets out. So is community-level fire protection, so is Federal deposit

insurance and public health requirements which include mandatory inoculations for children. Such programs respond to the sense of community, equity and practicality.

Instinctively, the American people have come to a recognition that all citizens must have access to comprehensive quality health care, not on the basis of income, employment status, age, sex, race, geography or education, but rather on the basis of their membership in the national community.

The single-payer model provides a clear approach to such inclusiveness in the provision of care to all while having the greatest potential for holding the political support of working people and the middle class.

In conclusion, the American people want a universal health care system, and we believe that polls and the public call for reform show that the public is far ahead of those of us who work inside the Washington beltway. They want a system where an inner city youth or a rural widow will receive the same care and same quality of care as the President of the United States. H.R. 1300 and S. 2330, among other bills, gives us confidence in the probability of this level of care as the norm.

A single-payer approach makes it possible for us to expand access and provide long-term care for the Nation's chronically ill population while holding down costs. S. 2320 will provide comprehensive community and home-based care in addition to institutional long-term care. As a practical matter, only the single-payer approach allows us to eliminate cost-sharing burdens which inhibit access to care and increase administrative costs. S. 2330 specifically bars cost-sharing.

The administrative savings of adopting S. 2320 were mentioned earlier. GAO says we will save $67 billion the first year by moving to a Canadian-style health care system. Other studies have suggested even greater savings. I believe the New England Journal of Medicine ran an article where they suggest $110 billion a year could be saved.

The adoption of H.R. 1300 and S. 2320 would not put the insurance industry out of business. Life, fire and auto insurance policies would continue to flourish. An interesting point as an aside is that a lot of the health insurance industry are taking their claims processing jobs and moving them overseas. Signa does a significant amount of their claims processing business in Ireland. Other companies are moving them to English-speaking countries in the Caribbean much as they do with credit card referrals and other things. Anything that can be done over the phone is actually being shipped out of the country.

We realize that some people are skeptical about the willingness of the American people to adapt to this change. You are about to hear the doubts of doctors, the hospital administrators, and the insurance industry. But we urge you to ask your voters, ask your seniors, ask your blue-collar workers, ask your white-collar workers and your middle-class professionals and small business persons, and not just their representatives like me.

They are prepared to talk to you about what they want. They want a national health care program that provides every American, young and old, with comprehensive, quality health care. They want

long-term care included. They want help in keeping costs down, and they want to make sure that the system is financed fairly and progressively. They want the rights of patients and families protected, including the right to choose their own doctors. They want healing and not redtape and paperwork.

This is also what the National Council wants and what S. 2320 gives the promise of making.

Thank you.

[The prepared statement of Mr. Lawniczak appears in the appendix.]

Senator MIKULSKI. Do you have membership in Maryland, Mr. Lawniczak?

Mr. LAWNICZAK. Yes. We have a large affiliate in the Maryland State Council of Senior Citizens. I believe you came to their meeting on Tuesday.

Senator MIKULSKI. Yes, that's what I thought. I thought that maybe one of the members would join you in the testimony

Mr. LAWNICZAK. Well, we did try to get someone, but unfortunately there were a couple of snafus involved, and no one was able to attend. We did make an effort to have someone here from the State council.

Senator MIKULSKI. Thank you.

Dr. Otto, we wondered what had happened to you, because we know you attend everything pretty much like Marty and Abe, who I have heard testify also at community meetings and so on. I had said that something must have slowed you down, and we were going to put your testimony in, but now we've got you here in person.

Mr. OTTO. Good morning. It was Route 702. That's where the difficulty arose. Somehow, I continued on Route 702 instead of staying on 675 until I came to Exit 39. The directions were quite explicit.

Senator MIKULSKI. Well, you probably went right down to Bethlehem Steel and ran into my pal Helen Bentley and made a U-turn to come back to me. They call us the "salt and pepper" of the Maryland Delegation, so no time lost.

If you have caught your breath, please proceed with your testimony, and then we'll go into some questions for this panel, particularly about affordability and coverage.

Mr. OTTO. Actually, my opening remarks will be pretty much as forwarded to you. I have taken notes on "Condition Critical." I suppose that most of you were able to observe that television show on April the 8th where many societal issues were developed, and I made a few notes, if I could share those with you after this.

I am Frederick F. Otto, AARP Maryland State Legislative Committee Chairman, speaking on behalf—I would hope—of approximately 600,000 American Association of Retired Persons in Maryland.

AARP members are deeply concerned about the sky-rocketing cost of health care and about the fact that some 34 million Americans, 570,000 Marylanders, have no health insurance, and another 20 million are underinsured, or about 340,000 Marylanders.

They are also concerned about the lack of a national long-term care program for the growing number of Americans of all ages who need such care. I think I heard the gentleman on my right refer

to the New England Journal of Medicine—I'm not sure it was in connection with this statement—estimating that 43 percent of all Americans reaching age 65 will spend some time in a nursing home and that one out of five of these will spend 5 years or longer in such a facility at a cost of at least $25,000 per year.

AARP believes that all Americans have a right to affordable, quality acute and long-term care as they need it throughout their lives. We are convinced that the United States has the resources to ensure access to acute and long-term care for all, and to control health care costs without compromising quality of care.

Any program that will provide all Americans with affordable acute and long-term health care will cost money and will require changes in the way health care is delivered and paid for in this country. But it is important to understand that the cost of not reforming our health care system will be even greater.

If we do nothing, the cost of health care will continue to rise faster than the overall inflation rate and will consume a greater and greater share of our national resources. Additionally, the number of individuals who are uninsured or underinsured or who find health insurance unaffordable is likely to grow. Businesses will likely continue to reduce the coverage they provide for workers and retirees, and continued attempts to solve our health care problems with piecemeal or bandaid solutions will only result in greater fragmentation of our health care system, more cost-shifting, and higher administrative costs.

For these reasons, and for philosophical, political, economic and pragmatic positions that cannot be developed here because of time limitations, AARP is working to develop a comprehensive national health care plan called "Health Care America" that controls costs and provides high quality coverage to everyone, including those who need long-term care.

The goals of AARP's draft proposal, then, are: (1) to control costs; (2) to assure access to care for everyone; (3) to provide comprehensive benefits including long-term care; and (4) to finance the system in a fair manner. The proposal is a draft that will be taken to the AARP membership during 1992 for debate, discussion, suggestions and modifications.

The cornerstone of Health Care America is the MEDICARD, a single health insurance access card for everyone. With this card, everyone, regardless of age, income or employment status, gains access to an improved and expanded Medicare program or to equivalent or better coverage provided through an employer. Either way, there will be no more denials of coverage for pre-existing conditions, no more people falling through the cracks, and no more overlapping plans and programs generating wasteful paperwork. The card assures access to the full range of preventive, acute care, prescription drug, and long-term care benefits. There is no cost-sharing for preventive services, hospice, or hospital care, and only 10 percent coinsurance for most other services.

For most individuals, it will no longer be necessary to purchase supplemental insurance. Strict cost controls, malpractice reforms, and elimination of waste and duplication keep the program affordable.

The need for health care reform has become so great that it overrides what some may view as an organizational self-interest. Although AARP derives considerable revenue from providing health insurance to members, the Association will gladly forego every penny of it in exchange for a national system that provides universal access to quality care, real cost containment, and a way to pay for it that is broad-based and fair.

Health Care American has the following important advantages: It is easy to use and understand. Every person gets a health insurance access card, MEDICARD, to present to the health care provider and receives one clear periodic accounting.

All of you have experienced the difficulty—perhaps some of you have even found it difficult to know when you have paid all of your health care bills because of the administrative networks. It is far more efficient than our current system. Streamlined administration and electronic billing reduce wasteful administrative overhead.

It controls costs using national and State budget targets, such as they do in Hawaii, for spending. It also establishes standard rates for providers, places strict limitations on prescription drug prices, prohibits balanced billing and reforms medical malpractice insurance to reduce unnecessary procedures.

It provides for comprehensive benefit coverage for all age groups. Everyone automatically qualifies, regardless of employment status or income.

It preserves the individual's freedom to choose health care providers, just like present-day Medicare.

It places new emphasis on preventive care, to catch small problems before they become expensive tragedies.

It provides all children with screening and treatment services to meet their dental, vision and hearing needs.

It protects the already sick. No one can be excluded on the basis of an existing condition.

It includes what most people don't have—long-term care coverage in the home, the community and nursing homes; prescription drugs, and affordable limits on total out-of-pocket expenses each year.

It strengthens vital health research and quality assurance programs so that our health care will continue to improve.

It stigmatizes no one on the basis of income. Protections are available for the poor and low-income without the drawbacks attached to the welfare-based Medicaid program. Medicaid is abolished.

It leaves employers free to provide the same or even more generous coverage for things like eyeglasses or dental work, through benefit plans that meet the same strict standards for coverage and cost containment.

Now the rub—paying for the plan.

Most people believe that we are already spending enough to pay for all the health care we need—figures suggest over $800 billion in 1992. This plan reduces administrative waste. But those savings are more than offset by the cost of greater benefits and services for all. Unfortunately, there is no free lunch. Improvements in coverage and the reduction in out-of-pocket costs must be balanced by

some increased tax revenues, even as the total costs of health care are held down.

Health Care America will lower out-of-pocket costs for most people. The real impact of the plan, however, is that it gives the American people for the first time a means to limit the year-to-year increases in the cost of health care. That statement was looked upon with doubt by a member that I met with on Monday. He said, "I took the data from the AARP plan and applied it to my own personal circumstance, and I can't believe that I'm going to be able to receive the benefits that I'm going to be able to receive for the cost that I computed."

It combines broader protection with effective controls on spending to provide real economic and health care security now and into the future. In order to make this possible, however, new taxes are necessary. AARP has identified several sources of funding that are adequate to pay for the plan.

"Sin" taxes on alcohol and tobacco would be doubled, reflecting the health costs associated with their use. Corporations would pay a 5 percent surtax on their existing corporate income tax, reflecting the substantial savings that the plan offers many of them in lower health costs. Estate tax rates would be brought back to the pre-1981 levels in order to help finance the long-term care protections.

The new Medicare premiums, $500 per month for an individual in 1993, would not exceed 20 percent of the cost of the improved and expanded Medicare program. Monthly premiums would be set according to family size. In effect, everyone enrolled in Medicare except those too poor to pay, would contribute monthly payments just as current Medicare beneficiaries do each month.

Employers would pay an 8 percent payroll tax. This tax would be waived for employers who provide equivalent or better coverage privately to their employees and dependents.

Employees covered under an employment plan would pay no more than 20 percent of the private plan premiums. Special provisions would protect new and low-wage businesses. The balance of the necessary funding would come from one of the following two revenue sources: (1) a special income tax of 3 percent that would apply to all income above $15,000 a year for individuals, or $20,000 a year for families, or (2) a new 5 percent tax on consumption called a value-added tax that would provide to all goods and services except food, housing and medical care. The tax would be refunded to low-income persons. Other tax adjustments would offset the regressive impact of a consumption tax.

This plan presented in summary form here has been developed in order to share with AARP members and the public a proposal that is built upon the principles for health care reform already adopted by AARP's board of directors. It is offered for discussion, debate, suggestions and modifications.

The association knows that any comprehensive health care reform plan will be controversial. We do not think controversy can be avoided if we are to fix the serious problems that our health care system faces. Debate is the essence of a democratic society. We hope this plan will move the health care reform debate close to resolution.

The following charts which I have attached—and copies, I believe, are available at the table at the rear for those of you who have come here today—and I believe that those who are here today are going to play a significant role in the implementation of a desirable health care reform plan and do recognize that what I have said here is subject to continuing debate for the next year; there are many arithmetical problems that need to be resolved, and all will not agree with the final solution when it comes—these charts reflect the cost-sharing concepts and also long-term care.

[The prepared statement of Mr. Otto appears in the appendix.]

Senator MIKULSKI. Thank you, Dr. Otto. We'll enter those charts into the record.

I'd like to now move for the next few minutes into some questions, and we thank you for your thoughtful testimony. Obviously, a lot of analysis went into this and a lot of discussion within your own groups, and we thank you for the thoroughness of the presentations.

One of the things that I hear as I move around is that there are the issues, of course, of access, affordability and coverage, one of which is the issue of understanding insurance and understanding, first, what you do have, and second, the very nature of the billing both from providers and then the reimbursement.

And while we've been talking about single-payer, this payer, all-payer, what about the payer, I'd like to just get some pictures from you, as regular people who use the system, as well as the abstract analysis of a future plan. One of the criteria, and John, one of the principles, should be that whatever means we come up with should be user-friendly, and English should be the first language that is used. I wonder if you could share with me right now what happens to either yourselves or your members in terms of just the very nature of understanding what they have and also the very nature of the billing process.

Does anybody want to take a crack at that?

Mr. OTTO. Well, my friend Tom Kaler, who is an attorney in Hagerstown, says, "I turn it over to Jean. I can't fathom it. I can't handle it." His wife handles the health care insurance.

As I indicated earlier, maybe some of you have difficulty knowing when your health bills have been paid, especially where you have a number of different procedures and a number of different forms to be completed. Therein lies the difficulties that I have experienced.

Senator MIKULSKI. And Dr. Otto, when you have been filling out those forms, does your provider—either the physician or whomever has done the intervention—fill out those forms for you, or do the seniors do it themselves?

Mr. OTTO. That has been improved considerably. Some insurance offices are accepting the forms which the doctor prepares and forwards.

Senator MIKULSKI. Abe? Marty?

Mr. WISH. Of course, under Medicare now, fortunately the change has been made that the provider has to send the form in; you start with that. But it is a crying shame—and I think this applies, unfortunately, to survivor annuities or survivors—that while the male bread winner in this society is involved in these things,

we don't tell enough about it to our wives who are going to be our survivors. As a result, when something happens, they are completely and utterly at bay and confused. It is a crying shame that in this society under those conditions, there are not for-profit outfits that do nothing but take care of what happens with your bills. There are any number of those around. So I think any system that we come up with must take into account the need for simplification of the process, whether it be a unified billing type thing or whatever. But that is a critical area.

Senator MIKULSKI. Abe?

Mr. BLOOM. I'd like to add something to that. A lot of people get caught in the fact that they have to do their own billing—the doctors will not do that for them—in which case they are so confused, and they don't do proper filling out of forms, and they actually lose money in the process. I think there have been estimates of millions of dollars that should be reimbursed and are not reimbursed.

I'd like to put in a plug for the single-payer plan. You go in, you show your card, and that's it. The doctor bills the single-payer and gets whatever he is entitled to, or he negotiates their fees from time to time. There is no problem with this at all.

Senator MIKULSKI. The kind of horror story I heard goes something like this. A person is treated at one of our fine hospitals. Let's just say he or she had a stroke. They go in for emergency care, they are stabilized, the stroke is not so impairing that they require a nursing home. And then let's just say they go to Good Samaritan here in Baltimore for rehab, and then they are able to go back home. Now, all of this might have taken about 6 weeks. And when they get back home, there are piles of papers. The kind of constituent call I get is from someone who, after wonderful speech therapy, will say in a slow voice, "Senator Mikulski, I had a stroke before I went into the hospital, but now that I'm home trying to figure all this out, I'm ready to have another one." They are bewildered first because they get bills that they thought were covered. Second, they get notices from the insurance company that say, "This is not a bill," but they don't know what it is. The whole process goes on, and then they will pay for interventions, or a consultant who popped into the bedside for 10 minutes or whatever, and some of these bills keep on coming for 6 months, 9 months. One senior citizen thought she finally had it all straightened out, and now is being billed 18 months later. She told me that, "If you don't remember to bill me, I'm too old to remember to pay you." But essentially there is continual confusing of both paperwork and coverage.

Is this characteristic of what you hear, John?

Mr. LAWNICZAK. Yes, this is actually very characteristic, and we get the same complaints from our members all across the country, not just in Maryland, that this is happening.

A big part of the problem is HCFA and their explanation of Medicare benefits. We have attended several meetings with them trying to make that more user-friendly, as it were, and they seem not to understand the need of people to be able to understand what needs to be paid and what doesn't need to be paid.

Another big problem we are having is that hospitals are unbundling a lot of services. A lot of services that were formally

covered under Part A and therefore would have been paid for in full by Medicare are suddenly being shifted over to Part B. EEG's, which used to be read at the bedside, which were under Part A, are now under Part B, and so you receive a separate billing for that. People just don't understand if they are in the hospital for Part A, everything is supposed to be covered—but then they get these other bills, and then they have no idea what to do, so they just pay the bills whether they need to or not.

Senator MIKULSKI. That's exactly right.

Mr. WISH. If I may, I might just mention the Medicare forms. I am delighted that more recently, in the last few months, they have revised the information they provide, and it is a lot more comprehensive, and it is an improvement. I think they ought to get credit for that.

Senator MIKULSKI. One of the things that we have consensus on even in this panel is that there are those who are advocating a single-payer system, and if Congress does not go to a single-payer system, at least go to a single insurance procedure or form so that all companies, whether they are public, Medicaid or Medicare or private—of which there are 1,500 insurance companies, and all are using different forms, which drive the providers berserk as well. Whatever we do, it needs to be user-friendly and oriented to the customer, not to the bureaucracy, public or private administering. Is that right?

Mr. WISH. That's exactly right.

Senator MIKULSKI. And that would be a significant aid in controlling cost and also for efficiency in the process.

Mr. OTTO. I used to work for a superintendent who suggested that no one speak for at least 15 seconds after he had made a statement, but because of the nature of this hearing I am going to jump right in here, anyway. I wanted to let what you said register, but true, from the "Phil Donahue Show" on April the 8th, he mentioned that there were 1,500 different insurers, followed by paperwork/administration, paperwork/administration, paperwork/administration. That's the story there.

Senator MIKULSKI. I want to ask about long-term care. There are a variety of ideas floating around, but one certain emerges—that there needs to be a mix between both a public program and a private program. There are many who say everybody ought to pay for their own long-term care insurance, and why don't people just go and buy their own policies? Senator Mikulski, you are in your 50s now, and you know two things—you are going to get older—that's not going to change—and some of the things that the panel said—the odds of at least one out of two women in the United States of America will be in a nursing home. Why don't you just help yourself?

I'm sure your members have heard that. What have been your experiences, and what would be your comments to those who say we don't need Government in that, and people ought to just take care of themselves?

Mr. BLOOM. How will people afford it who can't afford it? Long-term care is very high if you want to buy a policy, and the policies are very peculiar, too; very many times, you cannot collect on them.

So the whole business is very "iffy," and I think we need the kind of public program we are talking about.

Mr. WISH. I think what Mr. Bloom has said is exactly right. The cost of private insurance is completely prohibitive for most people who need it. It is very high. That, in addition to some of the small print, some of the policies—and now they have improved—that don't provide inflation protection and so on for the future—all of these things all up to the fact that, yes, there are some people, a very small minority really of seniors, who can afford that kind of protection. What we need is broad-based universal coverage. As I have indicated, this isn't just a senior problem.

Mr. LAWNICZAK. Consumers Union puts out their consumers reports, and they did a piece with regard to long-term care insurance, and they basically said that none of the plans were worth paying for because the benefits you would ultimately receive certainly weren't worth the cost that you were going to pay in. For one thing, you don't get the inflation coverage. You find out that all the restrictions placed on private long-term care insurance makes it so you never actually receive the payments even though you are in the nursing home.

This is a society problem and requires a societal solution, and the way we solve societal problems in this country is by having the Government act on our behalf. That's what we need to do in this instance.

Mr. OTTO. I listened to a consumer specialist not too long ago at the senior rally in Maryland. She was talking about health care and long-term care. The next morning she was on the "Today Show" talking about fish. But as a consumer specialist, naturally, she would be quite flexible in that regard.

Senator MIKULSKI. Your meetings sound like they'd be a lot of fun, Dr. Otto. [Laughter.]

Mr. OTTO. But she developed scenario after scenario, and after each scenario she asked, "Now do you think we're ready for long-term care insurance?" No. And she went through 15 different scenarios, and we never did quite reach the point of saying, "Yes, now we are prepared, and all of these conditions are met, to purchase long-term care insurance." And currently, as I understand it, it runs around $2,500 to $5,000 per year for people who may not use it in the long-term. And of course, there is very little provision that we can see for recovering that kind of an outlay once it has been made. And then the inflationary costs are frequently not examined very carefully by the would-be purchaser of long-term care insurance.

Another point, though. There is a trend in this country—I work with this now—I tried to retire, but I am now the executive director for the Commission on Aging. The mission of that commission is to keep people living independently, with dignity, for as long as possible. So any health care reform package should provide funding for those kinds of services that can be provided in the home—health care services, personal care services—because all of this is far less expensive than the $25,000 minimum for nursing home care, and that's a very minimum cost, believe me.

Mr. LAWNICZAK. If I may, one thing that a long-term care package also needs to include is concern and compassion for the

caregiver. We are often finding a generation of women who have raised their children and now find themselves looking after their parents or their husbands' parents. It is a thankless job, and it is a 24-hour-a-day job, and we need to be able to provide them with some help and assistance in order to maintain these people in their homes for as long as we can do so.

Senator MIKULSKI. Marty?

Mr. WISH. I just wanted to mention on long-term care, I know you are familiar with the fact that there is a long-term care campaign organization, and we have a group here in Maryland. But we should recognize the fact that this umbrella organization has 70 or 80—I don't remember the exact number—national organizations, from AARP to religious organizations to Families U.S.A. to NARFE and so on. All of them are involved and interested in this one issue, the issue being affordable long-term care, and not tomorrow, but today.

Senator MIKULSKI. It would be my intention to hold a separate hearing on the dimensions of that, because it has been my observation that a lot of this is open to fraud and abuse, not by the consumer, but it has been my observation that where there is a compelling and desperate human need, there is often greed, so there is quite a situation there.

Let me ask about one other dimension—and then we'll go on to those involved with providing insurance or being a broker and some others—the issue of prescription drugs. We heard earlier today a woman named Donna Welsh talk about how medical equipment is the lifeline for her son to be able to go to school and get out into the community. Now, prescription drugs, particularly the maintenance drugs or what I call the lifeline drugs—whether it is glycerine for the heart patient, the insulin for the diabetic, and so on—all of these drugs cumulatively are very expensive.

I wonder what your comments are on prescription drugs, where you have tried to provide in some instances even options for your members, what that experience has been, and any comments you'd like to make on that issue.

Mr. WISH. Fortunately, as I mentioned before, we have a system, the Federal Employee Health Benefits System—incidentally, which is a pioneer. That system was supposed to be and probably still is an example for the rest of the country as to what should happen—that, and what the unions did years ago in their negotiations.

But on prescription drugs, we are very fortunate because those who have Medicare and Blue Cross, or whatever the organization is under the Federal Employee Health Benefits system, we have full coverage on prescriptions at the present time. But we do recognize, forgetting that, that the escalation in cost of prescriptions for others of us who are not that fortunate is something that must be addressed; it is absolutely terrible.

Mr. BLOOM. Not only that, but the cost of prescription drugs begins to outstrip even the cost of going to the doctor in a hospital, because long-term costs are high. And the peculiar part about it is that these same drugs are available in foreign countries at much lower prices. Why is that possible?

Mr. OTTO. Pharmaceutical companies are entitled to receive funds over a period of time to pay for the research required to de-

velop these drugs. There is some suggestion, however, that some companies are retaining those research funds for far longer periods than they might necessarily need to.

Then there is the criticism about paying $8 for an aspirin tablet in the hospital. Hospitals are going to recover their costs one way or the other. As the system now exists, when we talk about the 34 million uninsured people, most of those people go to emergency rooms, and that is their only contact with the medical world. And that costs more for the hospitals to operate, and therefore those costs are passed on to the paying persons, frequently. Now, I don't know to what extent that exists, and I am sure it varies all over the country from hospital to hospital, but those are some of the realities of our existing problem of not providing universal health care and access to everyone.

Mr. LAWNICZAK. Many of our members are actually pretty lucky. We have a large contingent of union retirees that make up the National Council and the Maryland State Council. And when they retire, they have generally negotiated through their contracts a Medigap insurance policy which includes pharmaceuticals with a small copayment or maybe a deductible at best. But for the good majority of our members and for most seniors, they don't have this option, and if you buy a Medigap insurance policy which includes pharmaceuticals, it is very expensive. Certainly if you come from a working class background, you aren't going to be able to afford that kind of insurance policy. And when you go to the pharmacy and find out that your pills are going to cost $100, $200 a month just for maintenance drugs, it rapidly escalates into thousands of dollars a year. And people just aren't taking them. They are finding that they need to pay their rent instead, or they need to buy food, so they end up not taking them at all.

Senator MIKULSKI. Or they are cutting back. I have heard stories where people just cut their dose, but you can't cut your dose.

Mr. LAWNICZAK. Yes, or they take a pill every other day instead of every day, or every eight hours instead of every four. And these people end up back in the hospitals, back in the health care system, costing more health care dollars than they normally would have cost.

We are supportive of Senator Pryor's legislation, S. 2000, to rein in the health care pharmaceutical costs. But we are concerned that the pharmaceutical companies will continue to, in essence, gouge not just seniors but the American population as a whole.

Senator MIKULSKI. I am supporting that Pryor legislation, which essentially says that if you want the tax breaks associated with investing in Puerto Rico, you have to provide very strong cost controls, and that the rate of increase of a drug should be no more than the cost of inflation.

Like you, I was horrified to find that medications selling in a Western democracy like Germany were selling for far less than they were in West Baltimore or in Western Maryland, by the same company. That is just unacceptable.

I believe we need to learn from our democratic European counterparts on how we can do this. But I believe that what you are saying is contain cost, and you can contain cost without cutting quality by using simplified systems, by a common sense approach,

and also by cutting out the greed and cutting out the fraud. There are those—not the consumers—who are bilking Medicare for a substantial amount of money.

We thank this panel for their testimony.

Senator MIKULSKI. We'll now move on to the insurance panel.

We want to welcome a panel associated with the insurance community. We will be hearing from the CEO of Maryland Blue Cross and Blue Shield, Mr. Carl Sardegna; Ms. Betsy Morrison, vice president of financial services with a benefit planning and delivery service—at one time, it was called an "insurance broker," and now it is so tony—but it does require a very sophisticated approach that actually tries to go to the insurance field, these 1,500 different company and determines how to provide it to individuals or to businesses. Then we have Ms. Barbara Hill, who is president of the Prudential Health Care Plan, which I believe is one of the largest HMO's in Maryland.

Ms. HILL. That's right, Senator. It is.

Senator MIKULSKI. Prudential essentially is looking at this from the standpoint of both the provider and in one of the new modalities that originally was supposed to meet all of our concerns.

Know that I'm an old hand to this discussion, going back to my days in the House when I was on Congressman Waxman's committee and met and talked with many of you. I remember when President Carter offered his cost containment program, everything was going to be solved. Then DRG's were going to solve everything. Then we were going to have HMO's and PPO's, and Cheerios and everything else—now the only O's I believe in are the big O's in the new stadium.

We have now heard so many things, and of course, there are many people, as you know, who believe that the insurance industry is the problem. So this is a "no-fault" conversation. I'm acting here as kind of a Senatorial vacuum cleaner to pick up any and all ideas that I can on how we need to do it. So I look forward to your testimony, and I know you have been here listening to many of the consumers describe what they are up against.

So Mr. Sardegna, why don't we start with you, and then we'll go to Ms. Morrison and then Ms. Hill.

STATEMENTS OF CARL J. SARDEGNA, PRESIDENT, BLUE CROSS AND BLUE SHIELD OF MARYLAND, OWINGS MILLS, MD; BETSY MORRISON, VICE PRESIDENT OF FINANCIAL SERVICES, W.F. CORROON, HERGET DIVISION, OWINGS MILLS, MD; AND BARBARA HILL, PRESIDENT PRUDENTIAL HEALTH CARE PLAN, BALTIMORE, MD

Mr. SARDEGNA. Thank you, Senator Mikulski, and I am very pleased to have been asked to join in this panel.

I agree with your statement totally that we should not be about trying to find fault. It is a waste of energy. What we should be about is trying to find solutions. We are all a part of the problem, and we must all be part of the solution.

It is in that spirit that I would like to say that I have listened to a lot of the testimony and would concur that the health care system is in need of reform, and Blue Cross and Blue Shield agrees with that. In fact, in many ways, no one seems to be satisfied with

the way the system is working. It is too costly, and not enough people have access to it. Too many people—in fact, 35 million Americans—do not have health insurance. We agree that the administrative complexities and hassles are making it painful, almost as painful as the illness that may bring you into the system, to deal with it.

The piecemeal approaches that have sometimes been suggested, we do not think will work. It is time for bolder and much more comprehensive action.

If you were to look at the issue or the objective, I think there is general agreement. One, we need universal access, we need affordable cost of health care, and we need to do this while at the same time maintaining, or in fact, I think you can actually improve the quality of health while you bring down the costs and increase the access.

Currently, there are two programs that are most often mentioned as solutions to the problem. One is called the single-payer, and the "pay or play" plan. Quite honestly, I believe neither one will work. I think the single-payer in the long run will not work because if you look at the history of those countries who have employed single-payer over the long-term, they attempt to reduce costs by doing rationing in some form or other. Second, on the "pay or play," even in the best enactment of that proposal, one-third of the uninsured would remain uninsured. There is virtually no cost containment in the "pay or play" proposal, and in fact many think it will actually increase costs.

And finally, when you look at the cost of implementing either the single-payer or the "pay or play," it usually results in new funds, which in a country with the budget problem that we have, we cannot afford.

There is another alternative that is gaining increasing attention, and one that we would favor. It goes under a number of names. We call it the Consumer Choice proposal, which empowers the consumer and gets the consumer involved in the system and that we think will work.

The Consumer Choice proposal meets four fundamental objectives. One, it provides universal and continuous access. Two, it contains costs. Three, it preserves what is good about the system while attacking the fundamental problems. And four, and very importantly, it remains budget-neutral—no new funds would be needed.

What are the key features of the Consumer Choice proposal? Once again, it empowers the individual. It gives the individual purchasing power directly to shop for value among competing managed care system. It provides universal access regardless of health status or regardless in change in job or where you work.

It is based upon a progressive tax credit on income. Now, let me hasten to say, before everybody jumps and says that this is President Bush's proposal, that the only similarity between this proposal and President Bush's proposal is that it happens to use a tax credit. Beyond that, there is very little similarity.

The Consumer Choice plan first of all provides a universal tax credit to everyone in the country. It provides 100 percent of what would be necessary to purchase a standard benefit package at poverty or below poverty. It is scaled down to 50 percent for those

earning $100,000 or more. The curve of this tax credit is such that all families earning $50,000 or less would actually be better off financially under this proposal than they are under the current system.

The employer would be required to offer a standard policy and a more comprehensive package. It should be recognized that this standard policy would be very similar to the comprehensive policy that Blue Cross and Blue Shield offers now, with increased emphasis on prevention and prenatal care.

Medicaid recipients would be treated like everyone else. The acute care portion of Medicaid would be folded into the system, so we would not have a two-tier system as we have now. Medicare would not be touched.

Insurance carriers would be required to meet tough financial standards. They would have to control administrative costs. There would be a cap on total administrative costs. And because the tax credit would be costed out equal to the standard benefit, it would establish a target for all insurance companies, in a sense putting tremendous pressure on the insurance companies to offer that standard policy at or below that tax credit level. Providers would operate under an intense managed care environment.

As far as cost containment features are concerned, first and foremost, the individual would be involved. I do not believe we can solve the problem of cost if we attempt to attack it only on the supply side. We have got to also bring in the demand side. We are talking about aggressive managed care. We are talking about administrative efficiencies including the elimination of all medical underwriting. We are talking about the use of one—and I notice that you mentioned this—one, single claims form for all insurance. And it would eliminate cost-shifting. And finally, and not insignificantly, it would be budget-neutral.

How do you have a program like this and pay for it? Essentially, I believe there are sufficient funds within the system. The problem is they are not allocated equitably.

Let's take a look at the current system. Right now, there is a major hidden subsidy in the system in which we operate. Health care benefits are not taxed. If such benefits were taxed now, it would generate $65 billion nationally and $1 billion in the State of Maryland. If you take the 35 million uninsured and divide it into the $65 billion, that means roughly $2,000 per individual. Right now, Blue Cross and Blue Shield of Maryland can provide very comprehensive coverage for $2,000 per individual.

In addition, the tax is perverse in that since no one declares it on their W-2, those people at the higher income actually get a better benefit from that because their tax rate is higher. So we have a perverse system in effect.

The tax credit in a sense is a way of changing that and making it equitable and redistributing income.

Specifically how would you fund it? Health benefits would be taxed, but again remembering the curve would be such that people with $50,000 income or less would actually get a sufficient tax credit to offset the tax. Employers would pay a 4 percent payroll tax which, interestingly enough, is less than the 8 to 10 percent of payroll they now pay for health care.

Taxes from increased corporate earnings would be put into the pot. Since Federal and State funds would no longer be needed for Medicaid, that would also be put into the pot. And finally, you would essentially eliminate most if not all of the uncompensated care now suffered in the system, particularly in the hospital system.

Will it work?

We had analyses done by the Center for Policy Research and also by Lewin Associates. We tested this in Maryland, using it as a test case. It works. It comes out budget-neutral. Also, this system is in keeping with the culture of the United States in that in effect we are talking about individual involvement and managed competition.

I also noted the comments made by one of the previous speakers, talking about the Federal employee system. This would in many respects be similar to the Federal system in that in the Federal system, individuals in effect get what might be called a tax credit, and they have over 400 plans from which to choose. It is interesting to note that the costs of a system which the speaker said he felt was working pretty well except for long-term care—which I would agree with—actually have been less over the years than costs for private insurance. I think it is in large measure a result of the individual involvement.

Finally, there would be a major additional benefit to our economy. One, since it would reduce the costs for business, it would stimulate business and investment. Second, since municipalities and States tend to be among the largest employers, they would reap a major benefit. We estimate conservatively that should this proposal go into effect in Maryland in 1992, it would have saved the State $50 million. It would have saved the City of Baltimore $25 million. It would have saved Baltimore County $10 million. Those are conservative estimates.

What do we think the next step should be?

No. 1, we would encourage Congress, and we would certainly encourage local/State Government to pass small group market reform. Small group market reform attacks most immediately the needs we were talking about. It attacks pre-existing conditions, it attacks the issue of coverage from individuals moving from job to job. About 40 to 50 percent of the uninsured work for firms of under 50 employees. Second, we would encourage Federal funding for State demonstrations similar to the one that was proposed in Maryland in the House of Representatives. Interestingly enough, that bill passed 134 to nothing. It went down to defeat in the Senate, as you know, but in the House, that bill passed 134 to zero.

We feel that it is critically important that we test any proposal before we do it on a nationwide basis. Remember that we are talking about 13 to 14 percent of our GNP, one out of 14 jobs in the country. When most Federal programs or single-payers went into effect in other countries, their health care as a percentage of their GNP was generally in the area of 2 to 4 percent. We are talking about multiples of that.

And finally—and I want to congratulate Senator Mikulski—what we need is continued education and dialogue similar to what we are having here today, and I am pleased to be a part of it.

Thank you.

[The prepared statement of Mr. Sardegna appears in the appendix.]

Senator MIKULSKI. Thank you very much for that comprehensive and innovative statement. We'll come back with questions.

Ms. Morrison.

Ms. MORRISON. Senator Mikulski, I have put together a package which I am going to condense, but it is available in the back of the room. It also has a list of the resources that I used, in case people want more information from specific sources.

My name is Elizabeth Morrison. I am vice president of financial services for W.F. Corroon, Herget Division, in Baltimore. I am an insurance broker, which means that I go to the marketplace and shop for my clients in the area of life insurance, disability products and health insurance. I am wearing numerous hats here today, but one specifically—I am the current health representative for the Maryland State Life Underwriters.

I find myself in a very unusual position because I shop almost daily for my clients, and these are clients such as the speakers who preceded me on this panel today, saying, "I need help." And almost inevitably, for a whole mixture of reasons, they are backed into a corner where they are either uninsurable, or we cannot get insurance for them. So I am speaking today for a whole variety of people, and I am going to speak from my own experience in the last 14 years in health insurance, because I am convinced of the following: that health care is a multifaceted problem of access, cost and quality of care, and that previous attempts at curtailing these costs have simply resulted in cost-shifting.

Since there is a lot of legislation focused on access—and obviously, I am not a physician—I am going to focus my limited time on cost, or actually, the spending on health care. I think it is helpful to realize that until World War II, health care was paid for almost exclusively by the individual consumer. It was only at the time of World War II, when there was a ceiling on salaries, that the employers got involved, and because they could not raise salaries, they decided they would help their individual employees by helping them with some of their expenses, and those expenses were predominantly in the area of health care.

Prior to World War II, there were about 10, or maybe up to three dozen companies that were in the insurance business, and very shortly thereafter, only a decade later, there were 200 companies in the business. This was predominantly because of the tax laws which were favorable to the employers being able to deduct what they paid in premiums for their employees.

Now we are arriving at the 1990's, and expenditure is clearly out of control. As a community, we spend more annually on health care than any other industrialized Nation, and I feel very strongly that this information that is coming out indicates that we are unable to compete on a global basis economically because of the health care expenses that we have to build into any product that we bring to the market on an international basis.

For all our spending, we aren't the healthiest Nation. We don't live the longest. Thirty-five million or so of our citizens have limited or no access to health care, and our infant mortality is 50 per-

cent higher than Japan. We know we have a system that isn't working.

A lot of quick fixes have been tried. Insurers have shifted from community-based rates to experience-based rates, then to pooling smaller employers into trusts or like groups, then to offering guaranteed issue only to employees of a certain minimum size, and most recently, to the requirement of medical underwriting even to participate in an employer group health plan. We heard people speak earlier today who were subject to those restrictions.

Each of theses adjustments has reduced the risk pool, forcing employers to encourage employees with health problems out of the group and into various open enrollment options, forcing employees into "job lock," where they must stay with their current employers at all cost because it is the only way they can hold onto their health plans.

All of these steps are exclusionary, and none of them give people better quality care or lower cost or expand the coverage of those who do not have health care.

Many studies have gone into the research of what we are doing. We are seeing this today. And I think regardless of whatever plan we choose, there are specific things that absolutely have to be dealt with. The first is that whatever plan we choose, it must offer basic coverage to everyone. This means, in my feeling, incorporating the currently insured, the currently uninsured, Medicare, Medicaid and workmen's compensation coverage. Eighty-one percent of the uninsured are employed or are dependents of employees. The vast majority of the uninsured work for small employers who do not have the potential tax benefits of the larger employer.

Health care costs can comprise up to 40 percent of an individual employee's total benefit package for the very small employer. That drops down to 16 percent of the total employee benefit package for those employers who have 100 or more employees, and it drops even further for the employer of 10,000 or more; you're only talking 5.5 percent of the employee benefit package.

Small employers say that even if access is guaranteed, they simply cannot afford the new plans unless they are significantly less expensive than the plans that are available to them privately now. In addition, these plans are notoriously less generous with the benefits, and often require a very high percentage of participation, which smaller employers cannot reach.

One of the panelists at the very beginning had three employees. Most of the plans I am familiar with would require 100 percent participation of a group of under 10 employees. If several people are employed under their spouse's plan and have opted out, basically this leaves the other people unable to participate in a given plan.

We have over 23 States now which have passed legislation which allows or requires insurers to offer low-cost basic insurance, and 17 more States are considering—I think Maryland is in that category at this point. Both the Health Insurance Association of America and the National Association of Insurance Commissioners are advocating guaranteed access to coverage without penalty for pre-existing conditions.

However, a large number of State plans have not been the success that was anticipated at their start. Virginia in 1990 expected a tremendous turnout when they started with their plan. They have 350,000 uninsured Virginians. And yet by February of 1992, only 27 small employers had signed on. They were concerned because the State plan has high deductibles, high copays, and limited services.

What we are finding is in the long run, States like Florida have had more success because large employers have joined their State plan, and that has more readily balanced the plan.

We are also seeing another trend, and that is the problem of health care now is so extreme that some employers are offering cash bonuses to their employees not to join the plan. We are seeing individual bonuses of $500 to $1,000 a year for people not to put themselves or their dependents on their plans. And while some of these bonuses I feel are legitimate so that the individual won't be insured and the spouse insured redundantly, we are also finding that they are incentives to eliminate an employee who may have specifically, like the first panelist, a child who has significant health problems that aren't going to go away, and by taking that person off the plan, the employer can now move to another carrier and substantially reduce that employer's costs.

The second thing that I think is imperative is that whatever plan we choose must be a coordinated plan. We have at the moment insurance companies faced with coordinating 50 different plans in 50 different States, with 992 mandated benefits. Maryland, I am sure you are aware, leads the Nation with 35 separate mandates.

It is generally believed that these mandate in our State add 10 to 20 percent to the cost of health care premiums. And I will be the very first to say that I would be very unhappy to see all mandates eliminated, because I fought long and hard for some of these in Maryland. And I am not anxious for mammography, which we fought for before it became a State plan, to automatically be eliminated, because we have now convinced people that this preventive care is cost-effective.

What has happened, though, is that in the past, my own company—we analyze and work for large employers, and we show it as more cost-effective for them to self-insure. Those employers who self-insure are not obligated to follow the same requirements that the smaller companies do, so they can get around a lot of these mandates. We are also finding that it is more cost-effective for the smaller companies, even companies as small as 250 employees, are moving now to self-insured plans.

Over 88 percent of all self-insurers have modified their plans in the last 3 years to control cost. There have been a lot of studies recently that show that the PPO's—and I think we are going to hear from them shortly—are the most cost-effective on an annual basis as far as premiums are concerned. The HMO's cost about $2,600 per year per employee, the PPO plan, $2,900, and the indemnity plan is over $3,200. so there we are seeing a disparity of costs.

In 1990, 82 percent of the State governments and 54 percent of city governments offered HMO options to their employees. But all of these options add enormous administrative costs. I don't know

how many people are aware, but there is a control group that has been working very hard on reducing the enormous amount of paperwork, and the private insurers say that within 5 years, all of them can go to electronic billings, at a savings of literally millions of dollars annually. There are over 450 claim forms for enrollment and billing and so forth which can be dramatically reduced—one for enrollment and one for billing, or just a couple.

I'm not going to go over the technicalities of this. You can pick up a copy in the back. But I would like to mention one thing, and that is the area of fraud. We talk about purposeful fraud, but one of the areas that is becoming a very serious problem is that for the 34 million uninsured, workmen's compensation can be for them virtually the only way they have access to treatment. So we are seeing more and more back door access for health problems that did not happen on the job, but are going through the back door of workmen's compensation because that does not have a benefit period, and it doesn't have managed care, so it is clearly vulnerable to extended misuse.

I think whatever plan we choose, we must eliminate the opportunity to shift costs. In our system, we have pre-admission hospital procedure, we examine patient bills, the insurer checks the checker, who checks the checker, and all of this adds to costs, yet doesn't offer any additional health care benefits.

Other countries monitor the providers rather than the patients and the procedures, and they review physician results by geographic regions.

We are also aware of the cost-shifting that happens as a result of the uninsured who go to the hospital and as a result, those insurance costs are transferred to the people who have the insurance. Dr. Otto spoke specifically of that just a few minutes ago.

We absorb over $27 billion annually in the costs of the uninsured, and the inner city hospitals now are literally going broke. We have reached the point where there is no longer anyplace to absorb those costs.

Whatever plan we choose must curtail unnecessary medical treatment.

Senator MIKULSKI. Betsy, we have to clear the room at noon, and I want to be sure we have time for questions.

Ms. MORRISON. OK. What I'd like to do then, is move to the very last, and I am going to speak very specifically to a list of things that I would like to say whatever plan we do must include the following.

It should be a master plan requiring participation of all States.

It should incorporate uniform rate-setting.

Birth defects should be taken out of the system and solved on a structured settlement basis, by a panel similar to the program that is in place by the U.S. Department of Justice now.

Attorneys' fees for litigation should be placed on a sliding scale maximum.

Doctors should be encouraged to practice general medicine through the use of scholarships.

Physicians should be required to update training on a regular basis.

A national standards practices board should be created.

We should have procedures reviewed by geographic area.

Premiums, as Carl just said, should be charged on a sliding scale based on income, and incentives should be incorporated into employee premiums for good health care.

The rest of it, you can see in the written testimony.

Thank you.

Senator MIKULSKI. You meant incentives should be incorporated based on good health behavior.

Ms. MORRISON. Behavior, yes.

Senator MIKULSKI. That's different from health care.

Ms. MORRISON. Yes. I'm sorry. Behavior. I was rushing.

Senator MIKULSKI. That's okay. Which is essentially——

Ms. MORRISON. Non-use of tobacco—we have this in the life insurance premiums now—height to weight ratios; whether you are in a visible program of exercise on an ongoing basis, etc.

Mr. SARDEGNA. Wear seatbelts.

Ms. MORRISON. Yes, seatbelts are in here.

Senator MIKULSKI. Well, thank you, Betsy, and your whole statement is going to be in the record.

Ms. MORRISON. I understand.

[The prepared statement of Ms. Morrison appears in the appendix.]

Senator MIKULSKI. Ms. Hill.

Ms. HILL. Thank you, Senator Mikulski, ladies and gentlemen.

Here in Maryland, you could always count on three sure-fire signs that spring was coming: cherry blossoms, lacrosse, and the perennial General Assembly debate on mandating helmets for motorcyclists. Most States long ago passed helmet laws. The medical evidence in favor of helmets is overwhelming. The statistics are abundantly clear, and the consequences of not wearing a helmet are grisly.

So why didn't Maryland pass a helmet law years ago? Freedom of choice, of course; freedom to ride with the wind blowing through your hair; freedom to look tough and brave and cool.

In the end, however, it did come down to money. The Federal Government stepped in and said: No helmet law, no money. This year, Maryland passed a helmet law.

The debate over managed care reminds me of the debate over the helmet law. I could quote you study after study that shows that managed care not only saves money but provides superior care. The world is full of countries with managed care systems, with citizens healthier than ours. Why isn't managed care more popular in our country? Why, freedom of choice, of course; freedom to choose my own doctor; freedom for the doctor to prescribe as much care as he or she chooses; freedom to spend as much of other people's money as I want on whatever care I want, no matter how duplicative or ineffective or expensive that care might be.

In the end, it will come down to money. America cannot afford its current and lavish health care system of unmanaged care. And, at its current price, it cannot provide health care for all its citizens.

So we have choices. We could choose to ration care, as is being discussed in Oregon. But there are some of us who think it is foolish to talk about rationing care before we have achieved savings by managing it.

Still, as a proponent of managed care, I truly am sorry that Americans are only interested in managed care for saving money. I know I sound like a helmet manufacturer, but managed care really is good for you. We know there are those who believe in the myth that managed care is second class care, so I'd like to look at that myth with some examples, examples from my own plan.

First, just a word about our plan to put it into some perspective. We were founded in 1984 as the Johns Hopkins Health Plan, a unit of the Hopkins Health System. Since then, the plan has grown in size to more than 120,000 members, placing it in the top 15 percent of HMO's in the country. It joined the Prudential family in May of 1991, and its is now the second-largest of Prudential's more than 30 HMO's across the country.

Now, Myth Number 1: Managed care means second class treatment. We recently had a 5 year-old patient with leukemia. His oncologist at Hopkins believed he had a very good chance of recovery with chemotherapy in the hospital for several weeks. His parents really hated the idea of having him live in the hospital; it is not a very friendly place for anybody to live, but particularly for a child. Our medical staff spent hours and hours on the phone and in meetings with his doctors and others, making arrangements to care for him at home. The result was a treatment plan agreed to by the child's pediatrician, his oncologist, and his parents—chemotherapy administered at home by home health personnel with equipment, care, drugs and supplies provided by the plan. The child did beautifully, and everyone was pleased. And the cost of care was less, without any hospital bills to pay.

The same thing couldn't have happened in the world of indemnity insurance because no one would have been paid to sit on the phone for all those hours and make those arrangements. No pediatrician or oncologist would have done that, so the path of least resistance would have been taken—straight to the hospital door.

Another example—one near and dear to my feminist causes—is a woman member diagnosed with breast cancer. She went out of our managed care plan, using her husband's indemnity insurance, to see a surgeon recommended by her friends. The surgeon advised her to have a mastectomy with plastic surgery for reconstruction. Then, fortunately, the member decided to use her managed care benefits and called us to see about having us pay for her surgery. Our medical director got involved right away and got hold of the medical records. What did he discover? That the cancer was very small and not an aggressive type. What was aggressive was the surgeon. We sent her for a second opinion to one of our credentialed physicians who said mastectomy was totally unnecessary. The member had a lumpectomy performed, and has had no recurrence of cancer. We know because we see her in our screening program every 6 months.

The bottom line was less expensive care with a better outcome.

Myth Number 2: The only way HMO's save money is by denying care. The truth is one of the best ways of saving money is by providing care—the right care at the right time. Unlike indemnity insurance, which only pays when you are sick, HMO's focus on keeping you well.

In Baltimore, we have an innovative program that not only means better care for our members but saves taxpayers money, too. As Maryland's largest HMO serving the Medicaid population, we know the tremendous need for prenatal care among low-income expectant mothers. We know prenatal care will mean healthier lives for them and for their babies. We know the tremendous personal and public costs they and all of us will bear if prenatal care is neglected.

Traditional approaches to health care have not been particularly effective in addressing this need. The Medicaid population has shown a poor understanding of the need for prenatal care. So several years ago we created our "Better Beginnings" program. Better Beginnings pays cash to mothers to come in for prenatal care. We not only give them $10 for each visit, but we also give them useful gifts when their babies are born—a further incentive to stay in care. We'll even pay them $10 for seeing our nutritionist, our social worker, and a health educator—and we don't stop there. After the mother returns home, we send a nurse to visit her. The nurse examines both her and the baby, answers questions, and gives a short course on parenting. The nurse also has a chance to evaluate the mother's ability to care for her child, right down to such basics as does she have heat, refrigeration and water. The results—an enormous increase in our prenatal visits, fewer premature babies in the neonatal and intensive care units, and a better beginning for a lot of kids.

I could go on and on. In a society where many medical procedures are necessary and many more are preventable, there are lots of stories, stories whose themes are clear. Managed care is different, and it takes getting used to. But the outcome is better medical care that saves money—clearly a win-win.

Employers in Maryland have discovered that win-win. A recent Foster Higgins study showed that in the Mid-Atlantic region, HMO's cost 24 percent less than indemnity insurance, and PPO's cost 17 percent less. Those are important savings that can translate into coverage for a lot of people who now don't have any.

Eighty-five percent of the people in this country have health insurance, but 15 percent do not, and that is 35 million Americans, and that is 35 million more than any of us want. But let's not throw the baby out with the bath water by replacing coverage for all the Americans who currently have insurance with a national system that will solve the problem of access but not solve the problem of escalating costs. Let's control our costs with managed care and look at how to provide insurance to those who have none.

How can we do that? Well, two-thirds of those with no health insurance are employed, usually by a small employer who either cannot afford health insurance or can't get access to it because of the problem that everyone is experiencing with insurance companies being allowed to exclude those who are ill—that is called "cherry-picking." Let's raise the playing field.

Suggestions have been made to create health insurance purchasing commissions—independent agencies that would buy health insurance for small employers, pooling their employees as well as individuals into one large group to eliminate "cherry-picking."

We can change the rules about pre-existing conditions. Just as Mr. Sardegna said, most insurers agree that that is a bad policy, but no insurance company can be the only one to stop it. We all have to stop doing it at the same time, and that means you need a law to require everybody to change on the same date.

Give small employers tax credits to help them afford insurance. Give all employers tax incentives if the care they purchase for their employees is managed care. Extend managed care to those on Medicaid and Medicare, and save millions of dollars in tax money. Allow all those below the poverty level to have access to Medicaid, and allow the working poor to buy in on a sliding fee scale basis as they re-enter the work force. And establish practice guidelines that set standards that would make it clear that no insurer will pay for unnecessary or ineffective medical procedures, and all insurers will pay for procedures that we all agree constitute quality medical care.

The discussion earlier about claim forms—insurers would love to see universal claim forms for providers. Just as people talked about the problems with all of us having different forms, imagine if you will how many physicians there are out there, all using different billing forms which they then send to us. It is very difficult to create electronic systems for paying doctor bills if everyone bills you in a different way. That would create huge, huge savings for the insurers.

Are any of these easy answers? There are no easy answers to problems which face our friends and our neighbors, the health of those friends and neighbors, and the health of those they love. But radical surgery is not the right treatment plan for the problems we are facing. The prescription is to use a good dose of common sense to control costs and improve quality through managed care systems.

Thank you, Senator.

Senator MIKULSKI. Thank you.

Actually, this was a very creative panel and could have been a whole morning workshop, and know that this hearing is not the only conversation I'm going to be having with Marylanders on this issue.

Let me go to you, Betsy, and then a question to Barbara and a couple of questions for Mr. Sardegna.

First of all, whenever we hear testimony, or whenever small business meets with me, one of the issues we continue to hear about is malpractice reform. In your testimony, your suggested solutions talked about certain practitioner modifications. In Maryland—this gets to my point—we have done a lot of innovative things, with all-payer system—I'll come back to that with your ideal, Carl—the no-frills insurance that Cass Taylor pioneered and many of you worked on. And of course, Maryland passed malpractice reform.

My question is now where malpractice reform legislation has been passed, like in Maryland, was there a demonstrable reduction in premiums, or was it——

Ms. MORRISON. Yes and no. Let me tell you one of the things that happened that was very interesting. I think what happened is a number of the physicians went back to being insured by insurance

companies which were going to pay off in cases of serious malpractice.

There was a flight to off-site, offshore insurance companies, which were hollow contracts because we had reached the point where OB's were paying $35,000 a year for malpractice insurance. On the Eastern Shore in Peninsula General, a whole slew of OB's said, "That's it."

Senator MIKULSKI. No, no. I'm not talking about what the doctors pay. What I'm saying is this. The doctors come in, and they say, "Because I'm paying these high premiums, Senator, if I could have my malpractice insurance premiums lowered, this could be passed on to the way I"——

Ms. MORRISON. I didn't see anything specific, and I think you'd have to ask the other two panelists, but cause and effect, no, because other things were rising fast enough so that they took over.

Senator MIKULSKI. But that is one of the issues small business always says that if you limited malpractice cost—and there is no doubt that the physicians are paying high fees and so on—that then that would result in either lower fees that they charge their patients, and ultimately, insurance.

Carl?

Mr. SARDEGNA. Senator, the premiums for malpractice obviously add to the cost of insurance. But I believe the real problem is defensive medicine. That's really where the costs are. And I believe, going back to what Barbara talked about, there is an absolute need for us to develop practice standards. Once you have practice standards, then the physician is in a position to deal with the patient who sometimes, quite honestly, comes in and says, "My neighbor got an MRI. I've got a headache, and I want an MRI."

This way, if there are practice patterns which everyone in the community agrees to—and by the way, these are being developed nationally by superior institutions around the country, and Johns Hopkins is one, for glaucoma, but you can go around the country—develop that, and accept them as standards, have them enacted in Maryland or on a nationwide basis, then the physician need not practice defensive medicine, which is costing us far, far more than the premiums for malpractice. And you are going to wind up with more high-quality medicine because you can keep those practice standards up to the State of the art and communicate them.

If we can get that accomplished, we will go a long way toward solving one of the——

Senator MIKULSKI. Could you tell me what a practice guideline would be—and would that inhibit——

Mr. SARDEGNA. Innovation and so on?

Senator MIKULSKI. —no—the delivery of care.

Mr. SARDEGNA. No. In my opinion, it would not. A practice guideline would be—and now I'm going to get in way over my head——

Senator MIKULSKI. Actually, I'll ask the physicians this. What I'm interested in is when we use words, everybody here used words like COBRA's, HMO's——

Ms. HILL. A practice guideline, Senator, would be for instance in the case of a woman's breast cancer, at certain stages, certain chemical or radiation treatment would be the appropriate treatment for that stage of cancer at that stage of development, and it

would be considered the standard and the norm to treat it that way. So that a physician doesn't have to think to himself, "My God, have I done everything I have to do to keep from being sued?" Even though he may have done what he believes is the appropriate standard of care, he is so afraid of being sued because even though we have put a limit on the awards, if I'm a physician in good standing, I am just as concerned about having three suits won against me and how that besmirches my reputation as I am of having three big suits.

Senator MIKULSKI. So the practice guideline would not stifle the delivery of care.

Ms. HILL. No, no.

Mr. SARDEGNA. And actually will increase the quality, because the practice guideline is based upon the best State of the art.

Ms. HILL. And it would eliminate a bunch of duplicates.

Ms. MORRISON. It would also, I think, allow the very smallest, the most remote areas to have access to the best medicine that is available on a nationwide basis. And the computer system is in place. It is not that we need new technology. Just punch it up.

Senator MIKULSKI. OK. Also—and I'll follow this up with the individual providers when they testify later this afternoon—my question then will be that this then could remove what many of them tell me is almost an adversarial relationship in the doctor-client relationship, and the very nature of the doctor-patient relationship itself is often part of the therapy.

Mr. SARDEGNA. Absolutely.

Senator MIKULSKI. Confidence, trust, the ability to communicate, and not each seeing each other in a negative light.

Mr. SARDEGNA. By the way, I think you will find when you ask Dr. Nagel from MedChi, who is on one of the panels this afternoon, that physicians quite honestly have been very reluctant to do this because they are afraid of "cookbook medicine" or less generous—"Don't tell me how to practice medicine." Their opinion has changed. And I think if you ask Dr. Nagel, MedChi is ready to provide the data and to support that kind of a program.

Senator MIKULSKI. I think you've explained the way I was trying to express it through "cookbook medicine."

Coming back to "cookbook medicine"—this goes to managed care—you went through a lot of the myths that I have heard, one of which is that actually managed care is more bureaucratic, where a physician in Highlandtown or Hagerstown has to call some 800 number in Pennsylvania to talk to some anonymous person with whom he has no relationship to see can he admit, can he admit tomorrow, or can she admit, and so on and so on. Just the sheer ability of moving through the bureaucracy, they want to say the heck with it.

What about that?

Ms. HILL. I have heard that from physicians many times, and I know that complaint well. And I think some managed care companies do utilization management better than others. I do think having an 800 phone number in another State is not the right way to do it, and I think it is appropriate recent laws that say it needs to be done in the region where the care is being provided so that relationships can develop.

But I also think that most human beings don't like change, and physicians are just human beings like the rest of us——

Senator MIKULSKI. Understand the question—that the physician feels that he or she is being second-guessed by someone who does not know the patient, does not know the patient's circumstances. An example is where a physician hears someone talk to him over the phone, and he says, "I think I'd better admit you to the hospital, and it just so happens I don't have any patients, and I can meet you now and guide you through the process and get you settled."

Managed care says, "Oh, no. There is a 24-hour waiting period," almost like gun control, before you can do this.

So then the physician says, "All right. Go to the emergency room, and I'll meet you there." This means mega adding of cost, and then they feel that they have had to do all this consultation, which even goes with one of the testimonies—I can't remember if it was Betsy or Barbara who said we check the checkers rather than monitoring the providers, for patterns of practice and so on.

How does that affect, though, managed care?

Ms. HILL. Usually in managed care, the provider doesn't need to call for authorization to refer to a specialist or to get emergency services for a patient. They have to call for authorization to admit a patient for elective care, or after they have admitted the patient for emergency care, they need to call and let the managed care organization know that they have done it and what their treatment plan is.

I know that doctors who are unaccustomed in the fee-for-service world to calling and checking in with anybody about the care that they are doing feel as though big brother is suddenly watching over them, and find that offensive. Unfortunately, you can't save 24 percent off the cost of your health care dollar without having the system that manages the care and pulls all the pieces together get involved and start doing that. So that kind of a phone call is absolutely necessary, but it brings so many resources to bear. The managed care organization may say, "Doctor, are you aware of this recent research that shows that this and such might be a better mechanism for treating it? We happen to have a specialist who also works at your hospital. Maybe you'd like to have that doctor meet the patient in the emergency room." The resources of managing the case then come to bear.

Senator MIKULSKI. I see.

Betsy, I'm going to ask you to give me after this testimony three case examples of employers with less than 50 people with whom you have dealt, some that had successful outcomes, but how you had to essentially broker their situation, so we can see that.

The president of this school is waiting to talk to me, and we're running a little bit over, but Carl, the morning really cannot end without me going over your "Choice" idea. First of all, I'm not sure I understand it, so let me ask you these questions.

You talked about applying for a demonstration, and I'd like to know if there is an application is pending at HCFA, but then how is this provided? Is it an employer? Would the Choice plan be operated through an employer-based program? Could I hear a little bit about the plumbing?

Mr. SARDEGNA. Sure. By the way, when you get a chance, the testimony is in the back, and it might help.

Senator MIKULSKI. I have read the testimony, but I must say I cannot picture it working.

Mr. SARDEGNA. I know. It's a lot more complicated than to say "single-payer" or "pay or play."

Here is the way it would work. An individual would get a tax credit—let's say an individual at the poverty level—would get a tax credit. With that tax credit, that individual would be able to purchase, either at their place of employment, because the employer would be required to offer the standard package, or that individual would have the choice to go outside and purchase individually from the marketplace, very similar in some respects to the way the Federal plan works right now, because you almost in effect get a voucher from the Federal Government.

Senator MIKULSKI. OK. Let me devil's advocate with you the way I raised managed care with Barbara. When we say we're going to "shop," first of all, that implies several things: 1) a cornucopia of opportunity; 2) clarity and ease of knowing this. My question is isn't it unrealistic to believe that a lot of ordinary people aren't just going to be overwhelmed by the very nature of "shopping," and whom will they shop through, or are they just supposed to go through the Yellow Pages? Who will they shop through, and then also, in shopping around, suppose they have a pre-condition—and I'm not even talking about a catastrophic one, but one that is chronic and maintained, like diabetes.

Mr. SARDEGNA. First let's start with the idea that we're talking about a standard policy. In other words, there would be a standard policy that everybody would understand, very similar to, again, the Federal Government has a Blue Cross and Blue Shield standard policy——

Senator MIKULSKI. Now, let me tell you something, Mr. Sardegna. There are 300 different plans——

Mr. SARDEGNA. OK, let's forget the Federal Government.

Senator MIKULSKI. Marty was very kind about the retirees. I have been in hand-to-hand combat with Connie Newman on the Federal approach. If that's your model—whew.

Mr. SARDEGNA. OK, let's forget that. What you'd have is one, single——

Senator MIKULSKI. I, of course, have no opinion on the matter. [Laughter.]

Mr. SARDEGNA. I should have left the Federal program out. You have one, single basic plan so that anyone, whether it is in New York, Maryland or Oregon, who is going out and buying the standard plan would know at a minimum what they were getting. So they would first of all know what they were getting.

Most people will purchase it at the place of employment simply because at the place of employment you can get it at the group rates which are going to be more favorable. So it doesn't disturb the system. It does put that added pressure on the system, though, that in effect because you have a standard policy, and you have a credit that has been created that matches the actuarial value of those benefits, in effect, Senator, what you have is a standard of

cost against which the insurance company and everybody else will have to try to come in under that cost.

So the individual will know, number one, what the standard policy is, and number two, there will be a qualified carrier approach. You cannot be in the system unless you do at least a couple of things. One is you've got to pass certain very stringent financial screens. No. 2, you have to demonstrate you have the capacity for managed care. No. 3, you have to agree that your administrative costs will not exceed a certain amount. No. 4, you have to agree to use a single form—to just name a few.

Senator MIKULSKI. That's simplified.

Mr. SARDEGNA. Simplified. So you have a standard policy in that you know the company you purchase it from will have passed significant screens. And by the way, it requires no bureaucracy at all because essentially what you're really doing is using the tax system.

Senator MIKULSKI. Part of your testimony was that people are experiencing the consequences of their choices. I happen to believe in that. First of all, though, it shouldn't be a barrier, but there should be a consciousness. In a variety of situations that I am personally familiar with, what we hear is, "Don't worry, it won't cost you anything. Insurance will pay for it." So you get it—or they sell it to you, or they want to send it to you, or any number of other things. And of course, that is then paid for.

Could you tell us how the consequences of choices would be a form of conscious-raising and awareness development, and yet at the same time, people will say, gee, I don't want to do this because it might raise my premium or my deductible. Like in automobile insurance, sometimes you just get the windshield fixed, and don't call anybody.

Mr. SARDEGNA. Right now I would say that nine and one-half out of every ten employed people have no idea how much the employer is paying for their health care. What this would do would be to provide a tax credit on the individual's tax form. They would be very aware of the value of that money. It would become essentially their money.

Now, it can only be used to purchase health care, but it essentially would become their money, and I believe they would spend it wisely, which is missing now because you never see the 75 or 80 cents out of every dollar that you spend which is hidden in the cost that the employer bears.

So I think it puts the individual into the system in the way that they've never been involved before, and I personally believe you will never control health care costs as long as you try to do it from the supply side only. It's like trying to stop drugs from coming into this country by putting a ring of destroyers around the country. It will not happen unless you stop the demand for it.

Senator MIKULSKI. Well, I think there is no silver bullet solution.

Mr. SARDEGNA. No.

Senator MIKULSKI. I have many questions, but for today's conversation—because this has been a very creative panel in terms of the variety of ideas presented—I have one more question. I want to go to Medigap for a moment, because you heard the senior panel, and you know about the issue of prescription drugs.

Mr. SARDEGNA. Yes.

Senator MIKULSKI. You have had in your Medigap high-option at one point one that provided prescription medication. I understand that is now closed. Could you tell us—and again, this is no-fault—I understand from our other conversations that it is because the prescription drugs were so high for high-option. Could you tell us, if you would, number one, your experience in providing that, and number two, as we look at any national plan or any reform for Medicare, your thoughts on providing prescription medication? And you might also want to just give me a little cameo today and give me a more detailed response in writing.

Mr. SARDEGNA. Yes, I may have to give you a very short cameo, because I'm not sure of the details of the program, Senator.

Senator MIKULSKI. My ultimate question is will Congress be able to provide an insurance framework that will involve prescription drugs, or are we setting ourselves up for such failure because the costs would run way up. And actually, that was one of the things that was really a nail in the coffin of catastrophic—there were many coffins as well as many nails.

Mr. SARDEGNA. Well, the program that we're talking about in Consumer Choice, I believe, if you in fact get the individual involved—I'll go back to this because I think it is critical—that you can provide some coverage for drugs. I really think you can.

I also believe that we are on the threshold of starting to look at drugs from a managed care point of view as we have never looked at it before. It is in the backwater, and it is coming to the front. Mental and nervous came to the front before.

Senator MIKULSKI. And this would be almost like part of the practice guidelines?

Mr. SARDEGNA. Absolutely. And then you get formularies, for example. We have a program right now which is starting up where we can clearly demonstrate—without the use of generic drugs, but with the use of formularies—where in fact you can get the same impact as another drug, cutting the costs significantly.

So we are just at the beginning of doing that. I would not give up on the drug situation at all.

Senator MIKULSKI. I don't want to, either, but when you talk about involving the consumer, the consumer are involved for the simple reason that very few insurance policies actually cover it. So they know what they are getting. They also feel they have no choice, that when someone writes a medication for them, if somebody says, "George, you have to stop smoking," that's a choice; you either stop or you don't, and here are the consequences to you, not only your insurance rates, but the consequences to you. But when somebody is on insulin, or somebody for a variety of reasons might be on a well-known medication like Tagamet, they take it and have little choice about whether or not they take it. And yet at the same time, if we move it into insurance, there is the whole issue of cost.

Mr. SARDEGNA. I will give you a more detailed answer to that.

Senator MIKULSKI. I'd like to know what happened in Medigap because I think there are lessons to be learned. And when I ask about why the high-option was closed, again, the original Medigap high-option, with the exception of long-term care, nursing home, meaning custodial care, you really covered then what seniors view

as the ideal Medigap. And then the private sector said, wait a minute, because there are certain costs out of your control, because there are no cost controls on medication.

Mr. SARDEGNA. Absolutely.

Senator MIKULSKI. And in many instances, there is no competition because the very nature of it may be an individual pharmaceutical, unless it is generic—I don't know all that. But I think managed care, along with not only procedures, but pharmaceuticals.

So you would be talking about perhaps managed care combined with practice guidelines that would include procedures, pharmaceuticals and processes. We often talk about surgical intervention or pharmaceutical intervention, but very often there is a process intervention. And I don't only mean mental health, but for example, rehabilitation.

Ms. HILL. One of the important things, Senator, that managed care can do with pharmaceuticals is by developing what Carl was referring to, formularies, where you hand a book to the physicians and say if you are going to pick from these five drugs that all have the same action, pick this one every time unless there is a medical reason not to. Then the managed care companies can negotiate with the pharmaceutical companies for discounted prices based on volume. So instead of the pharmaceutical companies being able to charge their retail off-the-shelf price to the insurance companies, the insurance companies have the leverage to negotiate prices, which helps bring the premium for pharmaceuticals down.

Senator MIKULSKI. I know a lot of these ideas are pretty controversial.

Ms. HILL. That's correct.

Senator MIKULSKI. And I am not embracing them today; what I want to do is just get it out on the table.

Ms. MORRISON. Senator, there is another whole area, too, popping up in the area of pharmaceuticals, and that is, for instance, if you take high cholesterol, which everybody is focusing on now, there is a homeopathic series that is coming up that is very controversial. Instead of the Mevecor or what-have-you at $1 per pill ad infinitum, there are alternatives, another whole way of treating patients. That is a new area, too. So there are just numerous alternatives.

Senator MIKULSKI. Well, that's another whole topic. I believe that because traditional forms of medicine do not acknowledge bona fide and certified and those able to be licensed complementary forms, then they move into fringe areas, and I am a big believer in research in these complementary areas in terms of really determining their safety and efficacy, and knowing what they would then offer in a complementary way to our Western modality. But there has been such hesitation even to examine it, and then people want to go to Mexico and drink apricot juice to cure a problem—and maybe apricot juice is great, and we ought to look at it, but I believe we really need to do this. And there is a myth about over-the-counter drugs as well.

Well, I am now late for my appoint with the president, but that's okay; this was important.

This committee will stand in recess until 1:15.

Thank you.

[Whereupon, at 12:20 p.m., the committee recessed, to reconvene at 1:25 p.m. this same day.]

AFTERNOON SESSION

Senator MIKULSKI. The committee will come to order.

For those who missed the morning session, we heard from Maryland families, a special panel on senior citizens, we heard from Blue Cross and Blue Shield, we heard from someone who functions as an insurance broker serving medium to small sized business, trying to make insurance available to the "good guy" employers who want to at least try to provide insurance, and then we heard from Barbara Hill, who heads up the largest HMO in terms of innovative ideas on how to maintain costs in her mind without cutting quality.

This afternoon we are going to hear from a panel on business and labor people; then, later on, we'll hear from those who represent associations that would be regarded as individual providers—doctors, nurses, social workers, and optometrists—and last but not at all least, we'll be hearing from our institutional providers, those who provide long-term care, home care, as well as hospital care.

So as you can see, we're trying to do a lot today, and I will just share with everyone the way we have been proceeding. First of all, what I'd like to do in these hearings is act like a little Senate vacuum cleaner. I'm trying to pick up the best ideas I can as we're going to be moving on national health insurance and insurance reform, what are the best ways to do it. So know that I'm just trying to gather as many ideas and as many personal examples that people have experienced, and also approaches that have worked.

Also, in terms of the way that we have been running the hearing, it is in a "no fault" atmosphere. Very often, when people watch CNN or C-SPAN, particularly the kind of brutal hearings that went on in the Clarence Thomas hearings and so on—this is not spring hazing. For all of you who will be testifying, I am interested in the ideas; questions will be asked. If I am going to play devil's advocate, I will declare that. So right now, I am trying to gather ideas, and everyone can relax. No one is going to have to undergo a quizzing or a grilling. And I would hope my colleagues would learn from the way Senator Barb runs her hearings, and maybe we'd get more done. I'm sure you feel that when all is said and done, more gets said than gets done.

Now we'll move to our panel. I'm going to call upon you and then ask you to introduce yourselves as you testify, to tell us who you are and how you are involved in the health insurance debate.

Ms. Riley, why don't we start with you?

STATEMENTS OF ANITA RILEY, UNITED FOOD AND COMMERCIAL WORKERS LOCAL 27, TOWSON, MD; DON HILLIER, MNC FINANCIAL INC., BALTIMORE, MD; AND MARY AMELING, FREE STATE INDUSTRIES, INC., BALTIMORE, MD

Ms. RILEY. First of all, Joseph Kerhart, the executive assistant to the president of our local union, was supposed to testify today and unfortunately, due to a car accident, he is unable to be here.

My name is Anita Riley, and I am his assistant at United Food and Commercial Workers Local 27, and he has asked me to come and read his testimony for him.

Senator MIKULSKI. OK. Will you please tell Joe we are very sorry, and we hope it's nothing serious.

Ms. RILEY. It was pretty bad, but he is coming along real well.

Senator MIKULSKI. OK. We'll talk to you about that; we'd like to drop him a note, please.

Ms. RILEY. OK.

I am basically going to tell you that Joseph Kerhart is the executive assistant to the president of United Food and Commercial Workers Local 27. He is also the treasurer of the Baltimore Area labor-management committee. He serves as trustee on several large Taft-Hartley benefit funds and actively participates on many committees in support of health care reform.

Local 27 has the privilege to represent more than 27,000 members in Maryland, Delaware, parts of Pennsylvania, West Virginia and Virginia, and our international union represents approximately 1.3 million members nationwide.

Having participated in collective bargaining negotiations for our local union for over 20 years, Joe relates that he has witnessed a virtual revolution on the other side of the table. It used to be that the mere mention of the words "national health insurance" would bring an angry response from members of the management team. There would be loud references to "some sort of socialist plot," plus repeated breast-beating about the American health care system being the best in the world.

But now the revolution has come. Those same doomsayers are now conceding that virtually the only solution to the health care crisis is some form of national or mandated health insurance. They say they want very much go get the health care issue out of the collective bargaining arena entirely. We on the labor side of the table agree.

The shift has been very, very dramatic. It is no longer a question of whether we should have national or mandated health insurance, but when.

The change was sudden, but no more sudden than the skyrocketing cost of health care for our members. In one of our major contracts, for example, the cost of health care more than doubled from the beginning 3-year contract to the end of the next 3-year contract. That is impressive inflation. More than that, it positively boggles the mind.

Think what this means to the whole question of competitiveness. How can an American car company compete effectively with a foreign company when the American company is saddled with the full health care load while its competition gets health care through a national health care system?

But to me the most amazing development of all is a recent statement by the American Medical Association, which has been unalterably opposed to every aspect of social reform in medicine. Did any of you see the issue of the Journal of the American Medical Association which was devoted to clarion calls for health care reform? It was amazing. There were actually 13 separate resolutions proposed by the AMA.

Can you believe the statement by Dr. C. James Tupper, president of the American Medical Association, as faithfully reported in the New York Times—and I will quote—"The AMA's old style was to react and be against things. But there has been a philosophical change in our House of Delegates. We will be out front where the action is. We will stop being just selfish and only thinking of our own welfare. If we start taking good care of our patients, they will take care of us."

A startling statement, certainly, and very much overdue.

We welcome the American Medical Association and all the other forces that can be a factor in bringing this country to the end of the 20th century and into the 21st century.

Labor's message is apparently getting through. For decades now we have been saying that health care should be a right, that all Americans should have universal access to quality health care. We support a national or mandated system that covers every American and incorporates Medicare and Medicaid. The AFL-CIO recommends the establishment of a cost containment program to include a cap on health expenditures, a capital budget, and Federal authority to negotiate uniform reimbursement rates for all payers.

Compare the United States with the rest of the world. In 1990 we spent an estimated $675 billion on health care. That was one-third more than Canada spent to cover all of its citizens. That figure was twice as much as Germany and Japan spent for universal programs. Astonishingly, we have almost 40 million citizens with absolutely no coverage and millions more with inadequate coverage.

Labor believes we should create a national commission of consumers, labor, management, Government, and providers to administer the right program.

Labor doesn't have a buttoned-down mind on the issue. We think basic and specific goals for such a national system should include universal access, cost containment, and administrative overhaul, and we welcome the opportunity to discuss the legislative package that could achieve those goals.

Count on us for full support of your efforts to bring universal health care to all Americans.

Thank you.

Senator MIKULSKI. Thank you, Anita.

Mr. Hillier, we'd like to hear from you now. You are from MNC Financial, Inc., and I believe you have been active with something called the Labor-Business Council that came together feeling that neither of you, although each of you were involved in employee-employer relationships, had no control over the cost of health insurance, and you came together in a coalition. So we would like to hear, one, your experiences with the coalition, and also your ideas and insights. I heard you in Annapolis.

Mr. HILLIER. Thank you, Senator.

When I was in Annapolis, I was waving around a thing on my arm——

Senator MIKULSKI. That's right. Are you feeling better?

Mr. HILLIER. Yes, somewhat.

Senator MIKULSKI. And you had those wonderful nautical slides of sails.

Mr. HILLIER. Yes, sailing ships.

Senator MIKULSKI. Yes. I sail against the wind all the time. [Laughter.]

Mr. HILLIER. Well, it is a pleasure to be here. As matter of fact, Joe Kerhart and I work closely together in the Labor-Management Health Action Committee which several of us formed about 2 years ago. Ernie Crowfoot is the labor co-chair of that organization, and I am the management co-chair.

In last year's session of the State legislature, we had put together a proposal which would have created a data review commission which would have focused on ambulatory data to be collected and gathered an analyzed. That bill was defeated, so we decided that we were going to do that as a private initiative, so we have continued along that path, and that has resulted in a company that you may have been reading about called MEDALCO, which stands for Medical Data Analysis Company.

Let me just go back for a moment and turn to some of the things that I was planning to say in the written testimony that I have given to you. I am not going to repeat a lot of what you have been hearing over and over again, but I think the fact that so many people are saying the same thing means that it is extremely important. This Nation is spending, depending whether you're talking about 1990 dollars or 1991 dollars, $800 billion on health care—$800 billion. Within two to 3 years, that number will be $1 trillion. And we saw those numbers down in Annapolis in the presentations.

That is 14 percent of our gross national product. So we have by far the most expensive health care in the whole world. There is not another developed Nation in the world that spends more than 9 percent of its gross national product, and every one of those that is spending that much is providing care to every citizen. And yet we are leaving 40 million of our citizens not covered—or 37 million, depending on whose number you look at, but let's just say 40 million.

And yet our system is not serving us well. In spite of its tremendous expense, and the fact that at its best it does perform probably better than any other health care delivery system in the world, nevertheless on the average it is not doing that well. Our life expectancy and our infant mortality rates and a number of other measures do not compare favorably with other Western nations.

So I think a consensus has finally developed that the current structure is too flawed to be easily fixed. It must be restructured, and the nature of that restructuring has to provide more care to more citizens at a lower cost.

I think the United States has a certain degree of arrogance, and we think we are smarter than everybody else. Well, if we are so smart, how come we can't do health care for 9 percent of gross national product? Nobody else spends more than that. So I'd like to see us get into more of that mode.

I'm not going to talk about any particular proposals that are out there now, and there are thousands of them, and they tend to fall into three different categories, and you have heard those described by other speakers. But in looking at the various proposals that come along, there are certain things that I look for. One of the first

things that I look for—and this is obviously missing, because our Nation does not have a national health care policy; our Nation has to have a national health care policy. It doesn't need to be more than two pages long. It should address those fundamental features of what our health care delivery system is going to look like in the United States. And two of the things it has to address are access and cost. Access, to my way of thinking, if I were writing that piece of it, would say that every citizen should be provided health care. And if I were writing the cost piece of it, I would say it can't cost any more than 9 percent of our gross national product as a target to work for.

I am frankly tired of hearing people talking about being cost-neutral and not costing any more than we are spending now. We are spending too much now. And if we stay at 14 percent as the gross national product increases, we will continue to be spending far too much and not being competitive in the world and not doing an efficient job.

If you do a little bit of mathematics, at $800 billion and 14 percent of gross national product, every one percent of gross national product equates to $57 billion. If we in today's dollars had a health care delivery system that was at 9 percent rather than 14, it would save $285 billion. If we were at 9 percent, we would be spending $285 billion less right now than we are. Well, now, that is a great big number. If that doesn't get your attention, then I don't know what will.

You have probably heard the statement that if you were to cut the cost of the health care delivery system, that quality would suffer. Well, I think—and Barbara Hill would probably agree if she were still in the room—that that's not necessarily so. Efficient health care can be less expensive than it is in today's dollars, but just as good or better in terms of quality. And I think that the nations that are scraping by, if you want to call it that, on 9 percent of their GNP are providing as much quality to their citizens as measured by the outcomes as we are—or better.

Any of the proposals that come along also would have to be compatible with the United States culture that we have right now. Frankly, I think a single-payer system, while it might have a certain attractiveness in certain respects, a system that would put 1,499 out of our 1,500 health insurance companies out of business is going to have a hard time passing that test.

Whatever we come up with must effectively contain costs—and I don't mean just now, but I mean in the future. Carl Sardegna was talking about that in his comments. Some of the proposals that are out there really are totally absent in the area of effective ways to contain costs. So as far as I am concerned, that would have to be a strong feature of any proposal that I would personally endorse.

Towers-Perrin, which is a large consulting firm, recently published a survey which surveyed the benefits people, primarily in large corporations, in terms of the kinds of things that they would like to see going on—and there is a list in the material I gave you, so I won't bother to read that in the interest of time, because I did notice that you wanted us to keep it to five minutes. But there are several of them there.

Let me just go a little bit beyond what I put in my comments and talk about some things that I think might be practical. One is that we need to do some incremental things while we are waiting for the national solution. My belief is that the answer has to be initiated at the national level, and I don't think that is going to happen any time soon. I think it will happen eventually, but I don't think there is going to be a consensus on an approach. I am not seeing a consensus develop. I hope one does. In the meantime, we have to be working on some incremental things that we can be doing.

I would also suggest, as Carl has suggested, that several States or localities be designated as laboratories where different approaches can be developed and see which ones work, which ones don't, which ones could be expanded to a national scale and become perhaps the basis for a national system.

Let me just talk about three or four things that I think have promise that could be done, incremental things that could be done very soon.

You are all aware of the Medicare reimbursement system, the resource-based relative value scale, RBRVS for short. There are many companies that I am aware of, and unions, too, that are considering expanding the RBRVS concept into their own medical plans. That is a reimbursement system which has been carefully worked out with input from physicians right down the line in terms of being a fair way to compensate providers for their services. But why not expand that and use similar concepts in the medical plans that we are all using as an interim step? I won't go into all the implications of that, but there are many.

In Maryland, there is a proposal that has been submitted by the governor to the Robert Wood Johnson Foundation which would create a secure data utility, which would wind up being an electronic method by which physicians and other providers would put all their information into a system, and at its extreme, our whole health care delivery system in Maryland would become virtually paperless, and the cost savings would be so great that you could take those cost savings and use them to cover virtually all of our uninsured citizens if that's how you chose to use the money.

You have heard a lot of discussion about the data, you know, if you don't have information on where the money is going, then how can you get your arms around the problems that we have. I was just today given a report put out by Travelers. They quoted the Health Insurance Association of America as saying that one of the problems that we have is fraud; HIAA thinks that that fraud number is $60 billion a year. Well, how do you identify where fraud might be happening? One way to identify it is to have information—not just data, but information. MEDALCO, the company that I talked about, is working very hard to gather information that employers and unions and others—because we have arrangements with research communities, too—could use for those kinds of analyses.

Let me just finish with one last thing. Barbara Hill was talking about the implications of managed care and how managed care can really save money, and I believe that. In my company we have been proponents of managed care for a long time, and we have it in all

of our plans. Some of those concepts can be plucked out of HMO's and used even in an indemnity situation so that they are usable by companies that are not using HMO's or by smaller companies.

One that we have used—and we developed it in cooperation—Peggy Vaughn, who is Wilsie Associates medical director, and Wilsie Associates is a third party administrator here in Maryland—developed a product which we call CareTrack for us, but other groups are using it as well, and we implemented it on January 1st, and it takes many of the managed care concepts that you see in HMO's—a coordinator who coordinates all the care of patients with certain kinds of conditions—diabetes was an example that she used—to work with the family, work with the primary care provider, to work with the patients themselves, to be sure they get the very best care in the most appropriate setting, and it saves money every time, and the patient gets better care every time. That is something that anyone can use, and that can be used now, while we are waiting for the national solution. You know, what do you do in the meantime?

So I'll close on that point.

[The prepared statement of Mr. Hillier appears in the appendix.]

Senator MIKULSKI. Thank you very much, Mr. Hillier.

We want to turn now to Mary Ameling, who heads up Free State Industries, Inc. You are typical of a small business that has been bounced around. We spoke to Betsy Morrison this morning, an insurance broker who tries to work with folks like yourselves, and she also expressed her frustrations. Now we want to hear what you have had to deal with as you have tried to gain access to the system for yourself and your employees. And thank you for coming.

Ms. AMELING. As the Senator said, I am Mary Ameling, and I am president of Free State Industries. We are a construction equipment distributor here in Baltimore.

The health benefit crisis is an issue discussed almost daily in my office. This discussion is not because we enjoy talking about health issues, or that we have nothing else to do, but rather it is always, "What are we going to do? We can't go on continuing to pay these outrageous rates, not as a company nor as individuals."

In 1986 my company went from publicly owned to privately owned. From a corporation of 750 people, we went to a company of 26, grew to 70, and have now once again returned to 50.

With the drop in the employee numbers came a huge increase in health insurance rates to have the same benefits. We have tried for the sake of our employees to maintain the level of insurance previously offered by our owner. However, as years have gone by, chances of continuing to maintain such levels are now nonexistent.

In the past 6 years, every year we have made a change in the company providing our coverage. Why? Because after an initial, wonderful premium to entice us to join, the renewal rate is exorbitant. These rate increases have gone anywhere from 13 percent to 64 percent each year. This past year, our increase was 34 percent. So we switched to another carrier and have only minimum coverage, primarily catastrophic coverage, which was medically underwritten. I have to interject here that the 13 percent, the lowest increase that we got, was after we had submitted our application on this medically underwritten insurance policy. The day that we sub-

mitted them, my husband had a heart attack and caused the 13 percent increase on the originally quoted rate.

We at Free State have tried just about every form of coverage. We have had the typical Blue Cross/Blue Shield, we have had HMO's and PPO's, we have been self-insured, and now we have gone to catastrophic. We have tried offering what we call the cafeteria plan.

But what is the problem? All my people want to have the chance to have equal coverage. But that is not possible unless the company is able to pick up the majority of the premiums, and unfortunately, with the present economic times, the company cannot afford such a luxury. The salesperson who makes $60,000 a year can certainly better afford to pay $400 a month toward his coverage. But what about little Joe who, in order to cover himself and his wife, it will cost him pre-tax one-fifth of his income? Is it fair that he cannot receive the same coverage that the salesman can?

What has caused increases? Doctors who have ridiculous rates caused by the cost of malpractice insurance because we as a nation have nothing else to do except to sue. Doctors who charge insurance companies far more than they are willing to accept. For example, I had surgery a year ago. The doctor accepted $1,500; however, the bill that was submitted was $4,000—he had an explanation for that as well. Doctors who constantly get patients to return weekly or monthly for unneeded checkups at the rate of no less than $50 per visit. Doctors who encourage "well baby care" visits. I don't know about you, but when I was growing up, I went to the doctor when I was sick, not healthy. Pharmaceutical companies, who 10 years ago charged $2, now charge $50 for the same drug, making them the most profitable industry in the country. Hospitals who charge far more than what is used for your care.

As I said, my company is involved with the rental of equipment to construction sites, industry and Government. The only increases we have seen in the past 10 years are in the cost of the equipment and the overhead to keep the company afloat. However, the cost of staying well has gone over the hill. A normal person can literally not afford to get sick.

Truly today, I wonder if dying isn't cheaper.

[The prepared statement of Ms. Ameling appears in the appendix.]

Senator MIKULSKI. That was very powerful, Ms. Ameling, and I'll come back to you for questions.

Let me go to the United Food and Commercial Workers first. Now, United Food and Commercial Workers have a large contract with Giant.

Ms. RILEY. Yes.

Senator MIKULSKI. And even though I'm going to use company names, it is really for descriptive purposes. One of the outstanding relationships that I think has developed is the retirees.

Ms. RILEY. Yes.

Senator MIKULSKI. In my conversations—and you know, you can't be a political candidate without standing outside of a Giant. You see more people there, and you also have a chance—one of the ways I try to keep in touch with people is to every other week go

and shop in a different supermarket, and I learn a lot—bypassing the baloney and listening.

But Giant and also some of the other places talk about the retiree issue. Could you tell us about your experience with that, and do you know how many Food and Commercial Workers are covered, and then what does that mean to the premium? And then how does all this affect labor-management negotiations, because one of the things I worry about is generating jobs—jobs today and jobs tomorrow. And many are saying that we are now sinking under our health insurance for both our current employees and our retirees. But Giant has never said that. I just asked them their numbers, and the numbers were startling. And particularly where you have had a loyal work force, where you encourage people to stay with you, that moral and the relationship with the company, because that is productivity. Then they retire, and you are holding this, as compared to being at a competitive disadvantage with people who only hire temps, only hire people who work 17½ hours and are able to essentially eliminate that.

Ms. RILEY. Speaking of Giant, I will just use that as an example, we are going into major negotiations with the company in September, and health care is the number one issue that we are going to have to deal with.

We have a two-tier system in Giant Food, and the cost of health and welfare for the Tier 1 people, who are the older employees—not chronologically, I might add, but have been around for a long time——

Senator MIKULSKI. In terms of seniority.

Ms. RILEY. —right—their health care for full-time right now, by the end of this contract, will cost over $700 per month per person.

Senator MIKULSKI. Is that the retiree?

Ms. RILEY. No. That's the employee who is on-hand right now. We have—this is a ball park figure as far as retirees are concerned—we probably have 2,000 retirees——

Senator MIKULSKI. Seven hundred dollars a month.

Ms. RILEY. Yes, for Blue Cross/Blue Shield and the extras—drug, optical and dental.

Senator MIKULSKI. That's $8,400.

Ms. RILEY. Yes, it's very, very high. Now, come September, Senator Mikulski, that is going to be our major issue with the company is the cost. Even the second tier people, it is beginning to get a little outrageous; it's probably over $300 per person.

Senator MIKULSKI. But that's $3,600.

Ms. RILEY. Yes. And of course their benefits are not the same as the Tier 1 people. Of course, the Tier 1 people get the better benefits because of the longevity and because of the situation being that the cost is getting so exorbitant that somebody had to do something about it. These people could not possibly get what the other people get because the companies cannot afford it.

Senator MIKULSKI. Would you say this is one of the most serious problems in labor-management?

Ms. RILEY. Definitely. It's our number one issue, and it is our biggest problem come September, because we are dealing with Safeway also, and we're also dealing with Super Fresh. They are our three major food chains. And basically all the Tier 1 people

have the same benefit plan, which is the same cost. So where is it going to go? How is the employer going to foot the bill for this?

Our biggest problem is going to be where the company is going to come back to us, because up to this point, the employees don't pay anything. The company is paying the bill. We know that the company is either going to want to give them a lesser benefit, or they're going to come back and say you have to pay half the cost.

And as you said earlier, most of the people in the food stores are part-timers. There are very few full-time employees. They don't hire full-time anymore; they hire part-time. Now, who in the heck can spend that kind of money on health care when you are only working 20, 25 hours a week? It's just impossible.

So health care is the major issue. All the moneys that we negotiate for contracts, unfortunately—and not just Giant Food, but a lot of the other employers also—all the moneys that we generally negotiate, the employer wants to put into health care, which means that they're not really going to get anything else.

Senator MIKULSKI. So in other words, even where an employer says we're doing XYZ in health care, you aren't going to get a wage increase.

Ms. RILEY. If you do, it will be a very small wage increase.

Senator MIKULSKI. Nor will there be, say, in terms of opportunities—because there is a different kind of work force now, particularly with more women——

Ms. RILEY. Yes. A lot of single mothers, too.

Senator MIKULSKI [continuing]. So an employer is going to say, I'm not going to do something for day care for the young mother, because I'm paying either health insurance or the health insurance for the older worker. Is this all part of it?

Ms. RILEY. Oh, yes.

Senator MIKULSKI. In other words, because health insurance is so high, it affects wages, and then any other opportunities that essentially enable people even to stay in the work force, like help with day care.

Mr. Riley. Right. We have a lot of single mothers, too, and that doesn't help, either.

Speaking of retirees, I just want to make one point here. About 10 years ago, as part of our negotiations, the retirees did not pay any benefits. Then it went to $40, and then it went to $60. About a year and a half ago, it tripled; the cost absolutely tripled for retirees, and now they must pay $172 for their benefits, which is something they never had to do before, because of the rising costs.

Senator MIKULSKI. I see.

Ms. Ameling, what do you need to be able to provide health insurance for your employees? Obviously, you've made an extraordinary effort to find a way that you could do something.

Ms. AMELING. Literally what we're trying to do right now is just get our people to stop and think before they go and use a doctor. When we went to the catastrophic, obviously, it's only going to pay if they end up in the hospital. So we're trying to get them to actually stop and think about how many times they go to their doctors throughout the year, and is it really a necessary reason for going, or is it just that the doctor said I should bring my new baby back

in to make sure it is healthy, when they full well know that it is healthy.

We dropped our prescription card, and they stopped to think about how much they were paying each month toward that prescription card, plus the amount they had to pay as the copayment.

All of a sudden they started thinking: This doesn't make sense. I'm paying for all this. But in their minds they were saying: Oh, but if I block this out each month, then I'm not really paying it. But they really were paying it. Also, we had to change ours so that we made them pick up part of the premium while we were picking up the majority of it, and it was surprising—the more they had to pick up——

Senator MIKULSKI. I think those are very interesting recommendations on the consequences of behavior. But as an employer, would the kinds of things that Mr. Hillier was recommending like tax incentives that would enable you—for example, you as a small business cannot deduct the cost of your health insurance in the same way as, say, Chrysler or General Motors. As another example, the people who would run a Chrysler dealership do not have the same tax benefits as Chrysler Corporation itself in terms of deductibility. Would that be something that would help the small employer?

Ms. AMELING. Oh, I think anything is going to help us—tax benefits, anything to help us figure out how we can make sure that he has the same benefits as I do—anything, because I don't think a national health care system is going to take place very soon. And that's the only reason we just keep going back to our employees and saying, "You are going to have to control your costs because that's the only way we are going to be able to go back to the insurance companies"——

Senator MIKULSKI. Why do you think it won't happen soon?

Ms. AMELING. I just think it takes an awful long time to get through the Senate. And at this point, I don't think it has hit hard enough. Too many people can afford it at this point. There aren't enough who can't afford it versus who can afford it.

Senator MIKULSKI. Do you agree with that, Mr. Hillier?

Mr. HILLIER. Yes. There are so many different approaches to restructuring our health care system, and there does not seem to be consensus building around every one of them. Every one of them that I'm aware of has at least three fatal flaws. So I think it's going to be a while. I think we'll get there. And in an election year, that makes it even tougher. So I think it is going to be a while before we'll have true health care reform, yes.

Senator MIKULSKI. Well, I share your frustration. I find that there is such a significant gap between the compelling need for change articulated by people at the neighborhood level, whether they are a business, whether they are an ordinary family—everyone is talking about the need for change, and dramatic change, not tinkering change.

But I think it goes to, crucially—a lot of people say it's the money, it's the lobbyists, and a lot of that is part of the dynamic—but I agree with you, Mr. Hillier, that first of all, we don't have a national policy, so we don't know how to organize ourselves. A national policy would say what are we going to pay for, and what

are the most important elements of it—like preventive care, for example—and so on.

If I had my way, I would like to follow a model that we used in Desert Storm—now, I know everybody is saying, "What is she talking about?" Well, the President of the United States and the Congress of the United States were absolutely agreed on a national policy that Saddam Hussein had to be stopped. He had to be ejected from Kuwait. We all agreed that that was our policy. We were agreed on the objective we sought. Then we began a debate that occurred over a couple of weeks' time that was probably one of the finest things that I have participated in as a member of the United States Congress. We stopped everything, all the meetings, all the receptions, and all of that hoopla, and we told our staffs to leave us alone, because we knew we were voting on something that would determine the destiny of so many Americans in the United States of America. We were going to determine a declaration of war.

Why I say it was so wonderful is that we went to the meetings, we paid attention—yes, we listened to the polling—but not because we wanted to go by some whim or fashion. We understood the consequences. We listened to our constituents. And we knew that only we could be held accountable for this. We went to meetings after meetings, talked to many people, and then we began a prolonged public debate which as you might recall was one of the finest debates that the Nation has seen, and the Nation appreciated that. Then we ultimately took a vote.

All of that occurred over a three-week period. If I had my way to establish what is our national policy, and then suspend everything, that would be the only thing we would do, with a time certain for a vote. And then let the public watch this debate, participate in it, as we would lead into it, and then put aside everything else and just focus on this.

But you need a national policy. We had the national policy. We debated the means, and some of us, as you know, had very different views. But then once it was decided upon, we all embarked upon it with due speed. That is truly what I'd like to do. But in the absence of a national policy, I think we are going to fool around, and I think many in Congress are afraid of making mistakes rather than getting out there an advocating a change.

Let me ask a couple other questions, and then we'll move on to the providers. Do you think that malpractice reform will play a significant role in cutting costs?

Mr. HILLIER. Personally, I think that malpractice reform is a necessary thing to do. I don't see it has having the kind of dramatic impact that I think some people might. As malpractice premiums have started to come down again, we have not seen charges going down correspondingly. Some would say there are other things that are going up faster and are offsetting it.

Carl Sardegna was talking about protocols this morning. I think that that would probably be much more powerful—you know, let's grab this thing by the front end instead of the back end. If physicians had protocols which had been developed by the practice guidelines, which had been developed by themselves—this is the way you treat this condition at this step—then they would not have

to practice defensive medicine, and the number of lawsuits would go down. And yes, we need to have reform in the malpractice area as well, but that then would fade and become a relatively minor piece of the whole thing. I think a more important thing is getting people to practice in accordance with the practice guidelines in the first place, and then everything else recedes.

Senator MIKULSKI. Well, we're going to get some reaction to that managed care in a minute.

I'm going to ask each one of you if you had a chance to come to, say, a caucus of Senators, or to meet with the President, what would be the top couple of things that you would say? These are going to be among the things that I want to take back to this ongoing discussion.

What about you, Anita?

Ms. RILEY. Anything?

Senator MIKULSKI. Yes, focused on health care.

Ms. RILEY. I think what the doctors charge—is that what you are referring to, Senator?

Senator MIKULSKI. No. I'm saying to you here is the debate on national health insurance. If you yourself could be in the kinds of rooms I am in, what would be a couple of the points that you would want to make? Do you want to think about it for a minute?

Ms. RILEY. Yes, please.

Senator MIKULSKI. Ms. Ameling?

Ms. AMELING. I think I'd ask——

Senator MIKULSKI. Not ask. What would you say—one of which is, I think, "Move it." [Laughter.]

Ms. AMELING. Yes—make it a speedy change. Don't take the next four or 5 years to come up with a change in health care. We need it now. Five years—we'll all be dead before we can afford to go and get medical insurance. Make some change now, good or bad. At least make some change.

Ms. RILEY. Yes. I was going to say speed up the process a little bit. I think there is too much fooling around. I don't know whether it has to do with general politics, or whether it has to do with the lobbyists, as you said before, but something has got to give. I don't know whether people in the Congress or the Senate really don't care, because someone made a comment a few weeks ago that I found very interesting, and I don't know how true it is, but someone said that half the people we place in Congress never had a work a day in their lives because they are very wealthy people, and so they really don't understand what is going on out there or the people in general.

When you hear these things, you kind of wonder—maybe that's true. Don't they care? Don't they see what is going on here in the United States?

Senator MIKULSKI. I think they care, and you need to know that 80 percent of the U.S. Senate are millionaires. Senator Sarbanes and I laugh at our colleagues who we call the "dynasty Senators," while we are the "diner Senators."

Ms. AMELING. Well, isn't that the problem, because if you've got 80 percent who are millionaires, the cost of getting medical attention doesn't affect them.

Senator MIKULSKI. But most of them became millionaires through private sector routes; only very few are of inherited wealth. They ran their own companies or law firms or so on. But part of this is what you pay for, and then people are afraid. There is always going to be somebody who comes in and talks about a highly expensive, unusual procedure that they want covered routinely. So that is part of that hesitation.

What about you, Mr. Hillier?

Mr. HILLIER. I think you can probably guess that where I would start would be the necessity to develop a national health care policy which takes into consideration all the things that you have been hearing about concerns for long-term care, providing care for all of our citizens. Start with that, and you should be able to build consensus around that fairly quickly. And then start with a clean sheet of paper and say, okay, let's come up with a couple different approaches which will address each of those concerns. Then, having done that, now we have the real world of what is out there to deal with. Which one of these approaches is most implementable, and which one could we do, or how can we adjust the health care delivery system and also adjust the design of what we come up to have something that would actually be able to work.

Frankly, my own experience is that when you start off with a goal and you know where you are going, you're going to get there, and it's worth it spend the couple weeks of debates in Congress to get a consensus around that. Once you have done that, then you can move very quickly, and I would agree with everybody else that speed is of the essence. We are out of time.

Senator MIKULSKI. And so is this panel. So we want to thank you for being here.

Now we are going to hear from those who actually provide health care and get their insights, because they see it from both trying to deliver care and also trying to comply with all the insurance regulations.

We welcome Dr. Nagel, Ms. Eckardt, Ms. Rodgers, Ms. Wheeler, and Dr. Werthamer. And Dr. Hill, why don't you join us as well, from the Maryland Academy of Family Physicians.

We have heard a lot today, and when we talk about providing health care, you can see just the array of people at this table. And there are many other providers, individual specialties, individual modalities, but we needed to contain it a bit. But we want to acknowledge that the dental community also has very strong interest in this, as well as individual practice areas with special modalities like the delivery of psychiatric care. We appreciate that, and our record is going to remain open for others who wish to submit additional testimony. But we felt that you were kind of the minimum core, if you will, in terms of what is the team approach in giving care.

Dr. Nagel, why don't you start off? You are the president of MedChi, and you are representing the umbrella organization for physicians—knowing that there are many other individual areas of practice that would have liked to testify individually, but I guess you are going to be one of the generic docs.

STATEMENTS OF J. DAVID NAGEL, M.D., PRESIDENT, MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, BALTIMORE, MD; ADDIE ECKARDT, ADMINISTRATIVE DIRECTOR, RENAL SERVICES, BON SECOURS HOSPITAL, BALTIMORE, MD; DR. EARL HILL, MARYLAND ACADEMY OF FAMILY PHYSICIANS; EGON R. WERTHAMER, SECRETARY-TREASURER, AMERICAN OPTOMETRIC ASSOCIATION OF MARYLAND, BALTIMORE, MD; MARGERY F. RODGERS, PRESIDENT, AMERICAN PHYSICAL THERAPY ASSOCIATION OF MARYLAND, LARGO, MD; AND CAMILLE B. WHEELER, PRESIDENT, MARYLAND ASSOCIATION OF SOCIAL WORKERS, BALTIMORE COUNTY DEPARTMENT OF SOCIAL SERVICES, TOWSON, MD

Dr. NAGEL. Sure. A lot of docs don't like the word "generic." [Laughter.]

Senator MIKULSKI. I know that.

Dr. NAGEL. Senator, thank you for including us on the panel. It is certainly my privilege to be here. I have to preface my remarks by saying it was very hard to sit back there and listen to some of the testimony without responding. And I will not go into my prepared text too much, but perhaps our impromptu discussion afterward may reflect our views——

Senator MIKULSKI. Yes. Why don't you go through your text, and then later on we'll have some discussion.

Dr. NAGEL. The question is is it possible to have increased access to the health care system at less cost. We have all heard the cry, let's do something about our 35 million—or, Mr. Hill used 40 million—who are uninsured. But we have also heard cries who say our health care costs are too high. We must change the system so that it will cost us less, or at least cost us no more.

Some may say you can't have lower health care costs while providing more health care.

Now, to my point. How do we solve a problem if we can't really identify it? From what I have heard, it is very difficult to identify the problem. That is because it is a multifaceted problem.

Some legislators are prepared at this point to vote for implementation of the "Canadian" health care system in the United States. In the Canadian system, all people are "covered" for health care benefits, thereby solving part of the equation, that of access. However, some studies indicate that if the Canadian system were implemented in the United States, there would be a cost of about $2,500 per American household beyond their current health care costs. I'd like to know how those studies were developed and the criteria upon which they were conducted to get to those points.

Another point—rather than getting together to try to identify the real problem, with the exception of the meetings held by the Senator today and the Governors' conference that was privileged to hear the Senator back in November, precious little is being done to identify the problem. A plethora of solutions like the Canadian system are being cast as an answer.

A recent news article in the Washington Post in August of 1991 begins to shed some light on the problems affecting health care costs such as the rapid rise in HIV cases and the concomitant rise in health care costs, some estimating more than $75,000 per HIV

case for lifetime treatment; or, the problem of 375,000 drug-exposed babies, a much higher proportion than in Canada.

These social problems are not the same as in other countries. Indeed, violence in the United States is far greater than in any other country, with more than 20,000 homicides annually, some ten times greater than that of Great Britain or Germany and four times higher than that of Canada.

Even with this distinction between cost containment and increased accessibility, especially for the 35-40 million people without insurance, a general approach is still needed—a plan, if you will.

Perhaps we should look at developing some criteria for such a plan before we attempt to develop a solution. The criteria of a workable plan should include: 1) it should aim toward a workable approach, not creating an ongoing test of public policy based on who is the "stronger" elected official; 2) it must avoid direct governmental micro-management, relying a great deal on the economic incentives demonstrated over the years between patients and their physicians; 3) it should not be considered the end-all or panacea of the problem, but rather an ongoing attempt to try to "eat the elephant one bite at a time."

Most of you who are at least my age will remember physicians as the kindly, understanding gentleman who made housecalls and treated you even if you didn't have money or health insurance. I wonder how many of you remember those days, and how many of you think those days are gone forever.

Well, they probably are gone forever because nothing stays the same. There are televisions instead of radios, and video games instead of checkerboards.

Well, let me tell you that the vast majority of physicians in Maryland still see patients without compensation. In fact, a recent survey indicated that 20 percent of physicians in Maryland see Medicaid patients regularly and do not even bill for the care. One reason for this is that a physician is only paid $10.50 per day for caring for a Medicaid patient, and emergency physicians are paid $9.50 for a Medicaid emergency visit, and the cost of processing the paperwork after everything is said and done becomes more than what you are reimbursed.

But it is very important to know that nationally, it has been estimated that physicians are providing free, uncompensated care, amounting to $11 billion annually, for those who are uninsured.

Can health care services be delivered with high quality at affordable cost, and if so, how?

Well, we need to look at the following recommendations. We must encourage health promotion and disease prevention. Both physicians and patients need to be encouraged to become more active participants in health promotion and disease prevention, including teaching the public about healthier lifestyles. I'll just interject that I know that Mr. Hillier's program has emphasized just that process.

Such activities favorably affect not only the extent and quality of life, but also significantly reduce the cost of care. For example, one recent estimate indicates that 35 percent of all hospitalized patients are there due to alcohol or drug abuse problems. Health-related problems due to other lifestyle choices such as smoking have

been widely documented in recent years. Smoking is related to nearly 400,000 deaths each year in the United States, more than eight times the number of soldiers killed during the 10-year Vietnam War.

Second, patients should be free to choose, to determine from whom and the manner in which health care benefits are delivered. Patients should remain free to choose their physician and their health care delivery setting.

Third, implement reductions in the administrative costs of health care delivery and the excessive and complicated paperwork nightmare faced by patients and their families who seek to obtain benefits.

It is estimated that by reducing a lot of the paperwork of the Medicare and such, of the $800 billion spend in the United States, that we could save perhaps 10 percent, or $80 billion. Divide that among 37 million, and you come out with a nice number.

Fourth, encourage cost-conscious decisions by patients. Insurance companies, employers and Government programs should provide patients with clearer information prior to the service of the cost of such care and, more importantly, what benefits the insurance plans will provide.

Patients have to participate in making decisions about their own lives.

Fifth, we have to reduce health care costs through malpractice liability reform which, although it has been alluded to in the past, certainly there is concern about the administration's willingness to include that in any packages. However, we have heard that both sides of the aisle may be looking favorably at this. Clearly, the malpractice liability reform is important not only in the fact of reducing physician premiums, which is just the tip of the iceberg, but the cost of defensive medicine has been estimated at up to 7 percent of the technology that we have, and that number has to come down so we can spend the money on our patients, not on our lawyers.

It has been estimated that liability insurance premiums and defensive medicine add about 15 percent to the average physician's bill.

Senator, I think I have used my time. I'd be happy to answer questions later.

[The prepared statement of Dr. Nagel appears in the appendix.]

Senator MIKULSKI. Doctor, thank you very much, and we will be coming back to talk in more detail about malpractice. And you've heard a lot about managed care, and I'm going to ask you for some comments on that.

Ms. Eckardt? I'd like to hear from the nurses next—I'm going by the way the testimony is in my book, by the way.

Ms. ECKARDT. Senator Mikulski, panel members, colleagues, and those who want to improve the health of the citizens of Maryland.

Senator MIKULSKI. Excuse me, Ms. Eckardt. Could you tell me what "C.S." stands for? I see you have a master's degree in nursing. Is that from University of Maryland?

Ms. ECKARDT. Yes, it is. And "C.S." is "clinical specialist." I am a psychiatric mental health clinical specialist. That means that I

am certified as a clinical specialist by the American Nurses Association Certification Center.

Senator MIKULSKI. Thank you.

Ms. ECKARDT. I am Addie Eckardt, immediate past president of the Maryland Nurses Association and a resident of the Eastern Shore. Thank you for this opportunity to discuss nurses' perspectives on health care reform.

The Maryland Nurses Association is working very hard to design a health care system which improves access to care, quality of care and cost-effectiveness of care.

Maryland's 45,000 registered nurses deliver essential health care services which assist people attain and maintain their health. We also deliver services which promote health and prevent disease. Nurses work in all health care settings. Nurses also work in places where health care needs exist but which do not usually have health care providers present. These settings include schools, the workplace, and the community.

The Maryland Nurses Association is one of 53 State and Territorial constituents of the American Nurses Association. The ANA and 70 other nursing organizations, representing 700,000 nurses, have developed and endorsed "Nursing's Agenda for Health Care Reform," a bold new plan for the health care system of the future.

In October 1991, the Maryland Nurses Association and other nursing organizations sponsored the first Maryland Nursing Summit for Health Care Reform. Maryland has an active coalition of nurses who are currently working for health care reform. The coalition will continue to refine ideas and create an inventory of nursing's initiatives which have promise for the health care reform of which I talk.

We will do this through town meetings across the State to listen to consumers and to crystalize nurses' ideas about the problems, opportunities and solutions required to meet the health care needs of Maryland.

Nurses are frequently the first and sometimes the consumer's only point of contact with the health care system. However, restrictive reimbursement policies have aggravated the legacy of an illness-oriented, hospital-biased and health care provider-focused health care system. We are firm that one reform which must occur is the expansion of private and public insurer coverage to include the services provided by qualified nurses and other qualified nonphysician providers.

Expanding consumers' choice of primary care provider will reduce high-cost physician office or clinic visits, reduce emergency room visits, prevent hospitalization, and delay institutionalization. There are literally hundreds of studies which document improved quality of care and quality of life associated with the expanded practice of nursing.

Maryland, because of its Medicare waiver, is the only State offering an all-payer system which assures access to hospital care by regulation of reimbursement rates. Acute hospital care operates in a fashion similar to public utilities. The Maryland Nurses Association believes this has been an effective model and has potential for review by other States in considering a national health care reform plan.

Acute care, however, is only one components of health care services. Nurses in Maryland have found that by providing community-based services, health care can be provided earlier to vulnerable populations. Teaching and counseling by nurses prevents costly hospital care. There are mobile treatment teams in Maryland where nurses act as clinical case managers for the chronically mentally ill, treatment-resistant psychiatric clients living in the community. Health care services are coordinated by the nurse case managers. Through early intervention, prevention, teaching and counseling, costly, long-term psychiatric hospitalizations are reduced or can be avoided.

Another innovative example of allowing nursing knowledge to be implemented in a nontraditional way is a program which is meeting the needs of the homeless in Baltimore. Established by a group of nurse practitioners, "Paul's Place" is a model which fosters consumer responsibility for personal health, self care, and informed decisionmaking about health care services. Efforts are directed toward reducing fragmentation of the present system of health, social, educational and vocational services, and creating advocacy for special populations.

Maryland nurses are committed to delivering care whether the health needs are and where the people are—in homes, in schools, colleges, and in the workplace. Several pilot projects illustrate how nurses are implementing nursing knowledge in new ways.

Several nurse educators are currently involved in a project that provides information on creating a safe environment for older citizens living at home. Therefore, clients can remain in the home and reduce nursing home or other kinds of institutionalized settings. Nurse practitioners are providing health education and primary care services to high school students. Some of these children do not qualify for Medicaid, nor are they covered under parent's employer-based health care plan.

The nursing literature describes strategies such as nurse home visiting, which is not a new concept, which is reducing infant mortality and avoiding the use of costly, high-tech services for low birth weight babies. The long history of public health nursing in particular has shown the wisdom of prevention programs targeting infant, preschool and school age groups.

Senator MIKULSKI. Ms. Eckardt, maybe some of those case examples could be provided when we go to the Q and A. Could we go to your "Nursing's Agenda for Health Care Reform"?

Ms. ECKARDT. Sure. There are several key features for "Nursing's Agenda for Health Care Reform" which we believe are instrumental in effecting reform in Maryland.

First, we support universal access for all citizens, provided through a restructured health care system. This system will provide a State-defined package of essential health care services financed through a public plan and employer-based private plans.

A 1991 Maryland law defined a basic insurance benefits plan. Evaluation of the utilization and effectiveness of the implementation of this law and other laws that were introduced during last year's session will provide information needed for summer study in 1992 and for proposed legislation in 1993. We are closely monitor-

ing the implementation of this law and its articulation with proposed legislation.

There are 30,000 to 40,000 Marylanders who are uninsured. Because of the complexity of these uninsured needs, we do not feel an employer-provided health care system will have all the answers nor all the access for all citizens.

Senator MIKULSKI. Could we just go down the recommendations, and then elaborate on them later?

Ms. ECKARDT. OK.

The Maryland Nurses Association supports a shift in focus to provide a balanced distribution of scarce health care resources used to diagnose and treat disease, and the resources needed to promote health and prevent disease.

Third, we support enhanced consumer access to services by delivering primary health care in community-based settings.

Fourth, we believe in several further steps. If consumers have access to a full range of qualified health care providers, including advanced practice nurses such as nurse practitioners, certified nurse midwives, and clinical nurse specialists, aggregate health care costs will be reduced.

We believe that providing early treatment, prevention services and health promotion services at convenient sites, as I stated before, like schools, colleges, workplaces, churches and other settings, will increase access and make the system more user-friendly.

We believe that administrative costs can be reduced by automated health records, electronic billing, uniform claims forms—and that's a big one.

We support nursing case management, also called care coordination, for people who have continuing need for health care services.

And we believe that public and private funding for a comprehensive continuum of long-term care services must be provided while yet preventing personal and spousal impoverishment.

We also support insurance reforms such as community-basing premiums and mandatory coverage of pre-existing illnesses.

We have been actively involved in looking at a number of nursing initiatives which will provide solutions to our problems. We are pleased that we have several elements in place, and we will continue to explore and refine information and will be glad to supply you with that.

[The prepared statement of Ms. Eckardt appears in the appendix.]

Senator MIKULSKI. Well, first, Ms. Eckardt, know that your entire testimony is part of the record and anything additional that you'd like to provide.

We'll now go to Dr. Hill from the University of Maryland Medical School, and then to Dr. Werthamer, and then I will come back to the people involved in processes. We have the nurse who does both acute care as well as involved in the educational public health process. The physicians tend to be involved in procedures and some of the process. And then we'll do the rehabilitation and the counseling. That's the way I have tried to organize it. And I know everybody is a process, but that's not the way you're usually reimbursed.

Dr. Hill.

Dr. HILL. Madam Chair, my name is Earl Hill, M.D. I am not here representing the University of Maryland. My statement is submitted on behalf of the Maryland Academy of Family Physicians. In addition, I am a member of the board of directors and chairman of the Commission on Legislation and Governmental Affairs for the American Academy of Family Physicians.

I would like to commend you for holding this hearing on Marylanders' views about health care reform, and I particularly want to State that I appreciate your enabling me——

Senator MIKULSKI. Didn't you get an award? Do you remember when I came to that breakfast in Washington—you were named some big deal.

Dr. HILL. I appreciate it.

As you know, this month the AAFP released its proposals for assuring access to health care and strengthening our health care system for all Americans. The AAFP plan is supported by the Maryland Academy of Family Physicians.

"Prescription for Health: The Family Physicians' Access Plan" would provide for universal access to health insurance and effective control of rising health care costs. Whereas many other health reform plans also offer strategies to assure access and control costs—some of them similar to the prescription for health plan and some different—ours is the only one to address comprehensively a major failing in our health care delivery system—the severe shortage of generalist physicians.

In most countries, at least one-half of their physicians practice in the generalist specialties—family medicine, general practice, general internal medicine, and general pediatrics. In the United States, however, over 70 percent of all physicians are subspecialists. A growing body of research literature indicates that this vast overspecialization of medicine in the United States is a key source of our problems relating to access, rising health costs, and concerns about the appropriateness and quality of care.

I would draw your attention to two recently published articles which are submitted with this statement and will be part of my testimony. The first is authored by Barbara Starfield and compared ten nations on the basis of their primary care systems and found better public health outcomes and higher public satisfaction in nations where a generalist model of health care delivery predominates.

The second article, by Kravitz, Greenfield and others, studied treatment patterns across medical specialties and found generalists to be far more cost-effective due to their prudent use of hospital services, tests, and expensive procedures.

These and other studies confirm what is already intuitively obvious to many of us. A system of health care delivery based on a generalist model makes sense.

Patients need to have a well-trained generalist physician who is their ongoing source of health care, who can help them seek appropriate referrals to specialists when necessary and who can ensure that all medical care is properly coordinated, both to maximize the patient's health outcomes and to minimize costs.

Unfortunately in the United States today, while the vast majority of health care needs relate to primary care, the vast majority of our physicians are trained as subspecialists.

Without a sufficient generalist medical corps—at least 50 percent of all physicians should be generalists, and at least half of the generalists should be family physicians——

Senator MIKULSKI. I think you've made the point about the importance of the generalist.

Dr. HILL. There are certain components to this plan which I think are important. I think you should know that our plan assures universal access to health insurance primarily through employment-based plans with a publicly-sponsored plan providing health coverage for Americans not otherwise insured. Small employers and low-income individuals would be eligible for subsidies under the publicly-sponsored plan.

Our plan provides for a basic health benefits package that would offer comprehensive coverage with reasonable cost-sharing in certain instances. Insurance reform would ensure that coverage is offered in a nondiscriminatory manner and remains portable for people who change plans.

Our plan would control health care costs through a variety of reforms including the establishment of a national health care commission authorized to set a global budget for health care spending growth in the United States each year. These spending goals would be implemented by health plans at a local or State level and could be met through managed care arrangements and other means.

However, the national commission would have power to enforce spending growth limits in plans failing to meeting national targets, and if necessary by controlling the growth in provider fees.

To ensure meaningful access and affordability, our plan would promote various reforms to ensure that over time, at least 50 percent of all U.S. physicians are generalists.

Finally, our plan would require all Americans to have a personal physician, trained in one of the previously mentioned specialties, and to encourage participation in this model of care, health insurance plans would impose a coinsurance penalty on patients who seek nonemergency care from a subspecialist without referral from their personal physician.

A complete copy of this is available. I appreciate the time.

Thank you.

[The prepared statement and attachments of Dr. Hill appear in the appendix.]

Senator MIKULSKI. Thank you very much, Doctor. I think many of your recommendations parallel the legislation Senators Daschle and Wofford have introduced.

Dr. Werthamer.

Mr. WERTHAMER. Thank you, Senator.

As you know, I am Egon Werthamer, doctor of optometry, in private practice in East Baltimore, MD. I have been through the chairs of the Maryland Optometric Association and the American Optometric Association, and I appreciate the opportunity to appear before you to discuss health care reform.

As both a health care practitioner and a health care consumer, I am very much interested in the issue of health care reform. In

the interest of time, rather than reading the whole submitted testimony verbatim, I would like your permission to interpolate some personal observations in there.

Senator MIKULSKI. Yes, please do.

Mr. WERTHAMER. Obviously, we already discussed access. It should be available to everyone, but certain underserved populations should be particularly targeted to receive essential health care services, in both rural and metropolitan areas. Apropos to this, just this morning I received "AOA News," and 70 percent of all U.S. counties were medically underserved in 1990, according to a new report by the National Association of Community Health Centers. While most of those counties are in rural areas, nearly 75 percent of all underserved people are in metropolitan counties. So we are talking about 70 percent of all counties which contain 25 percent of the underserved people, and 75 percent are in metropolitan areas. These are people who are not getting the health care they deserve.

One way to improve access is to allow the patient to select the health care practitioner of their choice. There should be an emphasis on promoting and maintaining health through primary care and the expansion of public health functions. By promoting primary health care, the U.S. health care system can become proactive rather than reactive. This would reduce more costly care that is many times necessary when a condition or disease has progressed beyond a certain stage.

Our health care system has always been a crisis health care system. It never has been a preventive. Nobody has ever come together and said, hey, we spend $5 billion on preventive health care; we can save $100 billion or more on crisis health care.

I am particularly proud that my profession, optometry, has always placed preventive eye care as a priority item in its armamentarium.

Cost-effectiveness should be promoted. Cost-effectiveness can be accomplished through quality care measures—reducing unnecessary surgery, like 25 percent of the hysterectomies—and more efficient management of health care systems.

A couple months ago, we got some Medicare printouts back, and every one of them was denied. I called my contact person at Medicare, and she said, "Well, you know, Dr. Werthamer, we process 6 million claims a year, and we only have a 1 and 2 percent error rate."

I asked, "Why does all the 1 and 2 percent have to be in my office?" And we sent them all back, and they were all errors that they made. So we are all paying for those errors, plain and simple.

Whatever direction the health care debate takes, I would like to recommend that any legislation that is enacted include optometrists as equal providers who can provide services as authorized by State law. The best argument for this inclusion is Medicare, which defines optometrists as physicians for all covered services within the State Scope of Practice Act.

The Physician Payment Review Commission has also declared that optometric services are the same as those provided by doctors of medicine or osteopathy. And the Health Care Financing Admin-

istration has also said under the new fee schedule, optometric services will be the same as all other services.

In many of the health care reform proposals that have been introduced at both the State and Federal levels, there are provisions to eliminate mandated benefits because of their effect on the cost of health care. What I would like to do is point out the difference between mandated benefit laws and freedom of choice laws—and if there is one thing that you come away with from my testimony today, it is to understand the difference between mandated benefit laws and mandated provider laws.

There has been great confusion between those two. Mandated benefit laws actually require that a health care plan cover certain benefits such as coverage of mental health, foot care, cataract excisions, and so on. Freedom of choice laws, which are the mandated provider laws, only require that there be no discrimination of providers for services that are already covered by health insurance plans. So if you have a freedom of choice law, it does not increase the cost of services. It makes it more accessible, and may actually decrease the cost of services, because if we provide the same quality eye care services as an ophthalmologist but at a lesser cost, we are talking about money that is saved.

Access to health care services can be improved through freedom of choice laws. Optometric services are available in approximately 6,400 communities in the United States. In 4,000 of these communities, doctors of optometry are the only primary eye care provider. Optometrists provide approximately 60-70 percent of the primary diagnosis eye examinations in the United States. Thus many people who need eye care are relying on optometrists to provide such care.

Failure to maintain access to non M.D. health care providers in any national health care reform legislation seriously jeopardizes access not only to those who are already covered by health insurance, but also to the 37 million who are currently uninsured and the 40 million who are underinsured. That's the second thing I want to leave you with.

We are talking about health care reform. We are not talking about medical care reform. Health care reform includes physicians, but includes any number of other professions such as optometry, podiatry, psychologists, and they all have a role to play in a complete health care system.

I'm not going to repeat all the figures you have heard. The $800 billion—let's bring it down to something that you may understand. Americans are spending nearly $1.4 million per minute on medical care. In the same newspaper that I got this morning, the average household spent $8,000 on health costs in 1990, which made up a little better than 15 percent of the average family's personal income and almost 20 percent of its cash income. That means we're spending one-fifth of cash income on health costs.

Hopefully, by incorporating the principles that we have outlined, the health care system will become more efficient, making it more cost-effective and more accessible.

As optometry is only a small part of this giant health care system, I want to do and my profession wants to do what it can to make optometry part of the solution and not part of the problem.

Senator Mikulski, I appreciate the opportunity to present my views to you today.

[The prepared statement of Mr. Werthamer appear in the appendix.]

Senator MIKULSKI. Thank you, Doctor. That was a very quick-paced and comprehensive testimony.

Now, Ms. Rodgers, let's hear from you. You are here representing the Maryland OT Association and the Physical Therapy Association, as well as the rehab specialists.

Ms. RODGERS. My presentation today represents the views of the Maryland Occupational Therapy Association, the Maryland Physical Therapy Association, and the Maryland Division of Rehabilitative Services. We represent rehabilitation professionals providing services in hospitals, rehabilitation center, nursing homes, home health, and public and private practices.

Our three associations advocate reform which incorporates the principle of universal, nondiscriminatory access to a continuum of comprehensive benefits ranging from preventive to continuing care services. Assured appropriateness and quality of care, improved system efficiency and equitable cost containment should also be central goals of health care reform.

Inherent in these principles is in our view a need to recognize medical rehabilitation as an essential ingredient of basic, cost-effective quality health care.

While many of the legislative proposals pending before Congress contain positive and constructive features that are consistent with the principles we believe necessary to effective reform, others fall short in their efforts to address fundamental health care needs.

Rehabilitation services are individualized, goal-oriented medical services which are designed to maximize functional ability and promote quality of life and independence for individuals who, whether through accident, illness, congenital condition or birth injury, have acquired a temporary or permanent disability.

These services are multidisciplinary in nature and are provided by qualified health care professionals including occupational therapists and physical therapists.

It is estimated that over 253,000 Marylanders between the ages of 18 and 64 have conditions that interfere with their life activities and more than 125,000 are severely disabled, preventing them from working, attending school or maintaining a household.

The number of Americans with debilitating conditions are projected to increase significantly due to factors such as medical and technological advancements which save and prolong life, and the aging of our population. Medical rehabilitation services have proven to be a necessary and cost-effective treatment for the conditions that prevent Americans from maximizing their potential.

Persons benefiting from rehabilitation services include individuals who have sustained a heart attack or stroke, have arthritis, cancer, or a neurological disorder, have undergone an amputation or joint replacement, have developed sensory deficits or have chronic intractable pain, have experienced a traumatic accident or debilitating illness, or suffer from chronic pulmonary disease, and children who are born with or develop physical impairments. Medical rehabilitation speeds recovery, prevents recurrence or

rehospitalization, and maximizes the restoration of functional capacity. Rehabilitation services are essential to ensure that these individuals can function as independently as possible and return to their homes, communities, and particularly their jobs.

Rehabilitation has proved a cost-effective alternative to extended institutional acute care, as a variety of studies have demonstrated. For example, a survey conducted by the Health Insurance Association of America, of its member companies found a savings of $11 for every $1 invested in rehabilitative services, and a savings per claimant of between $1,500 and $250,000. Similar results have been demonstrated in studies conducted by insurance and case management companies.

We endorse the following principles and recommend that Congress incorporate these elements in any health care reform initiative: that all Americans, regardless of age, income, disability or employment, must have access to a basic package of appropriate, affordable and quality health care. Access should be based on health care need as opposed to the employment status or income level. Discriminatory health insurance industry practices should be eliminated. Arbitrary rating and underwriting practices, such as exclusions based on pre-existing health conditions and waiting periods, are unfair and particularly discriminate against persons with disabilities. Continuity and portability of coverage should be assured for all Americans.

Health care reform should ensure the availability of a full range of services necessary to provide a continuum of quality care and should provide adequate access to these services in the most appropriate settings. A core health benefits package must include coverage for medical rehabilitation services in hospitals and home and community-based settings. Benefits should also be included for items that are critically important to achieving functional independence such as prosthetics, orthotics, durable medical equipment, and assistive technology.

The promotion of appropriate, quality care is essential to a health care system that values outcome while containing system costs. A central element of reform should be accelerated efforts to develop research-based, multidisciplinary practice protocols to verify therapeutic effectiveness and provide guidance to practitioners and consumers alike.

From the medical rehabilitation perspective, measures of quality and appropriateness should be based on defined standards of care which incorporate uniform functional assessment and outcomes measures.

We support a coordinated health care system that assures individuals the type and level of treatment most appropriate to their medical condition. However, we are concerned that flaws inherent in many of today's managed care models would be continued and promoted by health reform proposals that mandate managed care. Certain current and contemplated forms of managed care can create disincentives for treating persons with disabilities and other persons suffering from severe disease or injury.

Neither managed care nor individual case management should be considered a panacea in the quest for reform of the health care system. Case managers must be trained professionals with a clinical

understanding of rehabilitation and the unique health care needs of persons with disabilities to assure appropriate, quality care.

As you know, there continues to be a critical need for additional rehabilitation professionals. As Congress considers legislation authorizing support for allied health care personnel, we urge that priority be given to funding schools of physical therapy, occupational therapy, rehabilitative nursing, speech pathology and audiology.

An efficient and equitable health care system should appropriately distribute resources as well as responsibility, and must include effective and fair cost containment mechanisms.

A balanced health care system demands that emphasis and resources be distributed along a continuum of care, beginning with preventive services and including acute care, rehabilitation and continuing care services.

Health care reform must provide incentives to reduce unnecessary and duplicate health care and administrative costs. Cost containment efforts should not be based on inadequate reimbursement for health care providers or limited, noncomprehensive benefit packages. Efforts to control system costs predicated on noncomprehensive benefit packages and insufficient reimbursement for health care providers will not promote system efficiency and will stifle efforts to promote quality health care and successful health outcomes for all Americans.

Senator MIKULSKI. Do you want to just move on down to employment-based coverage and the public plan?

Ms. RODGERS. Both look at the same. Specifically, the revision of S. 1227 that has been reported by the Labor and Human Resources Committee——

Senator MIKULSKI. That's the "pay or play" plan.

Ms. RODGERS [continuing]. That's right. All of those are basic medical coverage, and they do not specifically mention rehabilitative services. They exclude rehabilitative services both in the employer-based coverage and in the AmeriCare plan. If these are implemented, it will in fact put us back behind what our current benefits are today.

In summary, Senator, our country has the best acute care in the world. Our commitment to rehabilitation must equal our commitment to saving lives. If rehabilitative services are not provided, people will be institutionalized or re-institutionalized at a much greater cost both in financial and human terms.

Thank you.

[The prepared statement of Ms. Rodgers appears in the appendix.]

Senator MIKULSKI. Thank you very much, Ms. Rodgers. Being on Senator Kennedy's committee, we moved S. 1227, and I had many serious reservations about that bill. But we moved it in the committee to try to jump-start the actual movement of the process.

I feel that although the community feels an urgency, as you have heard from the previous panel, there is a Seragoca Sea or a glacial-like quality to moving this. And I want to acknowledge that the "pay or play" bill does not have the rehab services in it, and I objected to that in my conversations with Senator Kennedy, and I know some of the other members did as well. I will come back to that in the discussion. And many of the issues that you have raised

concern about are also parallel with what Dr. Nagel has raised, about these so-called mechanisms of control.

Now, Ms. Wheeler, let's hear from my own field, social worker. I couldn't hold a hearing without having an M.S.W. They'd run me out of the Corps, they'd rip off my buttons, burn my diploma.

Ms. WHEELER. We would never do that, Senator.

I am Camille Wheeler, and I am the president of the Maryland chapter of the National Association of Social Workers. We represent 135,000 professional social workers nationwide and about 3,500 social workers here in Maryland.

I will not go through my entire statement, but will say briefly that we as an organization have developed a replacement plan for the current way the health care system is delivered in this country, a proposal that is a single-payer, publicly administered system.

Those people who have much greater intellectual depth than I do have certainly studied this subject extensively. My testimony supports the idea that this is by far the bets way to deliver health care in this country; it speaks to the whole question of access, and it also speaks to the point of cost, and I'm not going to go through that because I know that has been discussed here extensively already today.

We are prepared to talk about how this kind of a plan gets paid for as well as the common criticism having to do with the rationing of care if you have national health.

In my professional life, I am also director of the Baltimore County Department of Social Services, so I'll make two points that are not in this testimony. One is that increasingly we see people driven onto the public welfare system because of the need for health care. It is not accessible to them. The people who are not covered in this country are the working class people for the most part. They often have to leave work and receive public welfare because with it comes a medical assistant card. In that also is escalating costs for the States, which is causing us all problems as taxpayers.

The other thing I want to say is that much of what we do has to do with things like child abuse and all of that. I am impressed particularly in other countries where they have national health that much of the provision of services in order to avoid child abuse and those sorts of problems comes through their national health system. I think in this country we would be well-served if we were more progressive with regard to how we deliver the health care services.

Thank you very much.

[The prepared statement of Ms. Wheeler appears in the appendix.]

Senator MIKULSKI. Thank you, Ms. Wheeler. The entire testimony will be included in the record, and if the national association wants to submit additional testimony—I know they have come by to see me about their comprehensive plan—and they are to be congratulated that they just went ahead and developed one, long before there was "pay or play" and so on.

Now I want to ask some questions. Ordinarily, we would ask what plan do you support—there are 30 different plans around. What I am trying to get is a core set of elements that would accom-

plish our goals of access, affordability and containment of cost without sacrificing quality.

Very often, those who come and testify in Washington are those who represent not only national associations, which I appreciate, and many of them you belong to, but are also think tanks or academicians who do not have to live with the consequences of what we do. They advise us, but they do not have to live with the consequences.

So for example, if a major university, Dr. Nagel, comes in and says we should have managed care, and they go through a whole technical thing, they might live with it ultimately as a patient, but unlike yourself or Ms. Rodgers or any of the others at this table, they don't have it. So that is why I'm going to move away from those kinds of Washington questions and go to questions affecting the way it would really work in practice and what you are also finding out in the street as you are dealing with people.

One of my questions to you, Doctor, is do you find that the current situation around money, health insurance, co-insurance and so on, interferes with the doctor-patient relationship? Do you find that the very nature of this chaotic and unsatisfactory situation interferes?

Dr. NAGEL. Senator, if I had known you were going to ask that question, I would have brought a letter to the editor——

Senator MIKULSKI. I want to get to the human aspect here.

Dr. NAGEL. In 1985, I wrote a letter to the editor of the Sun papers, saying that the current reimbursement systems are impacting the doctor-patient relationship. That was in 1985. There is no doubt that the current reimbursement systems impact from the standpoint of depersonalization to physicians having to make choices, whether it is de facto or really, about what services they will recommend to their patients, and that is flat-out wrong—but it is real. And the answer is obviously yes.

In terms of managed care situations, the American Medical Association has not opposed managed care, but looks at it very seriously with the concept that physicians should do the management of care. So in that respect we are in favor of managed care as long as physicians—and I think Dr. Hill's program certain would point to that—the primary care physician would be the "best manager" of care.

Senator MIKULSKI. And who manages it now?

Dr. NAGEL. Pretty much the patient; they can go wherever they want. They can have an X-ray done three straight days in a row if they choose three different doctors. There is no universal way of knowing these things. And you can have a physician who may be rushed and doesn't have an opportunity to find out that the patient had an X-ray. The specific example is the drug abuser, who can get three prescriptions from three different doctors in the same day. Now, I understand that the health department is setting up ways to track that.

Senator MIKULSKI. And that could also be true of someone who would be the white-collar junkie, the valium junkie, the amphetamine junkie.

Dr. NAGEL. Oh, absolutely—the senior citizen who has found a way—we had a presentation from a physician at the Hershey Medi-

cal Center who said you can ask your average patient coming in, and they are on seven medicines.

Senator MIKULSKI. One of the issues that I hear—and I will raise this with you and then anyone else on the panel, the physicians, and the other part of the health team—first of all, anything that we have ever heard in the Congress about cost containment has been a bust. And I have been at this now for over a decade. First, HMO's were going to solve everything. If we only had mandated HMO's, they were going to solve everything. Then we were going to have PPO's, and they were going to solve everything. Everybody looks for the silver bullet. In terms of hospitals, it was going to be DRG's, and we'll be hearing from them later. Now we hear managed care.

It seems like we spend a lot of money on rearrangement of structures without necessarily being able to contain cost. And now, even as I hear managed care, there seems to be confusion about that—does this mean that it would interfere with your practice decisions? Does it mean that you are going to call—and if you were hear this morning, I asked Barbara Hill this—an 800 number, and you're going to get an anonymous person in Pennsylvania or the Cayman Islands for whom you have no idea even what their expertise is, and then say you can't administer this drug or do that procedure, and so on and so on. That is one area of concern I have.

I'd like to know what your thoughts might be on cost containment and then also what you think of practice guidelines.

Dr. NAGEL. Let me just say on the managed care that I think it's the buzz word of the 1990's——

Senator MIKULSKI. It is, just like the second opinions and so on.

Dr. NAGEL. Right. I think if one looks at the issue of case management as opposed to managed care, an example of that would be the discussion with Mr. Sardegna. If you take 100 doctors, only 15 of those doctors probably need to have utilization review. So don't spend the money on the other 85 doctors; spend it somewhere else.

Now, the 15 doctors—do case management. Now the responsibility is with irresponsible doctor or an irresponsible patient or an irresponsible payor. You've now got it down to wherever the irresponsibility is. If it is with the patient, the insurance carrier can say, "I'm sorry, Mr. Smith. Given the set of circumstances, I know you want this, but this isn't within the now practice parameters and guidelines that the physicians have set up in conjunction with the other payers." And that is where the practice parameters come in.

AMA has been in the process with the specialty societies of developing close to 700 practice parameters already, so we're onboard with this. We need to tie it in to things such as case management and malpractice tort reform.

Senator MIKULSKI. Dr. Werthamer?

Mr. Werthamer. One of your qualifications was there should be quality of care. Having been a private practitioner, and still am, and having worked with a managed care system locally, I could not render the same quality of care under the managed care system. Why couldn't I? No. 1, I did not get the best of equipment. My office is up-to-date, and I have the best equipment; there, I get sec-

ondhand or maybe thirdhand or antiquated equipment, and I could not do as well.

Second, in my office, I could spend as much time as I wanted to bring that case to successful conclusion and make sure the outcome was okay. With managed care, I had to see a patient every 15 minutes whether I was finished or was not, without anybody to work him up ahead of time. I had to see four patients an hour, and I was booked for four hours. You cannot render quality eye care under those kinds of circumstances. That is the reason I left, because I don't want to compromise the standards that I set for myself.

Senator MIKULSKI. I understand, and I am familiar with where your practice is in the Broadway area. First, you have senior citizens, many of whom tell their story in more anecdotal ways. Also, as I understand your population, you serve people whose first language is not English—the older Eastern European immigrants, some of the new Hispanic members of our community—and it takes a bit of time even to find out what they want you to look at. Isn't that correct?

Mr. Werthamer. Luckily, being born in Europe, I know a few of those little phrases.

Senator MIKULSKI. But still, in other words, it takes a little more time.

Dr. Hill, did you want to say anything, or Ms. Rodgers.

Dr. HILL. In terms of case management, I agree with Dr. Nagel that "case management" is a preferred word. I think what we are trying to do is look at outcomes. We're looking at walking a particular pathway and achieving the best possible outcomes for the patient that we can in the most cost-effective manner.

Now, when people are able to go to the buffet and pick whatever they want whenever they want because cost is no object—which is a translation for "I'm not paying for it"—although they really are——

Senator MIKULSKI. That's right—actually, we all are.

Dr. HILL. The point is there is no control over that system. But if somebody comes to me and gets an examination and finds out they don't need to go to a thoracic surgeon first, and they don't have to go to a cardiologist to have a mega-workup because they have chest pain, but it's that they were too active shoveling dirt the day before, and they now have muscle strain, there is a significant cost saving immediately, and then it is up to me to convince them that I have enough expertise to say that, yes, indeed, you do have only muscle pain, and it will resolve.

And what have I charged them? Maybe $25 or $30 versus $3,500 for a workup. So the cost saving implications are obvious.

Senator MIKULSKI. That's an interesting point, though. The case manager is somebody with expertise and who also has an ongoing relationship with the individual as compared to an anonymous person with artificially created criteria for the delivery of care, like seeing somebody every 15 minutes.

So Dr. Nagel, let's just say a patient comes in, and this is the seventh time in 1 year where they have really insisted on being sent to Hopkins or a Prince George's County counterpart, and they say I want an MRI, I've got this and that, and you just know there

is a pattern here where the patient himself seems to have no awareness and wants the most high-tech for what you already know is sinusitis.

Dr. NAGEL. That problem is faced by the physician day in and day out as to where to draw the line between practicing what is "good medicine" and what is defensive medicine and just covering your own backside.

Fortunately, in my own practice in Baltimore County, I have a cadre of patients with whom I don't really have to face that, but the problem is there.

With practice parameters and guidelines, the physician will have much safer grounds to actuate that decision and say, "I recognize this is what you want. These are the criteria I have used to make my judgment. You have the right to seek a second opinion."

Senator MIKULSKI. So the practice guidelines would be very welcome, then.

Dr. NAGEL. Certainly.

Senator MIKULSKI. And also wouldn't that again de-emphasize this almost adversarial—I use the word "adversarial"—relationship where you are afraid that the person across from you is going to mention a situation to somebody, like their son who is practicing "lawyer law" or "combat law"?

Dr. NAGEL. That's exactly right. Practice parameters would be very beneficial in that respect. Actually, we have some physicians who don't want to hear it because it is, quote, "cookbook medicine," but as it is being developed through specialty societies, it is not "cookbook medicine"; it is good medicine.

Senator MIKULSKI. And then ultimately, it's not the parameter, but it is your skill in the delivering of the protocol.

Dr. NAGEL. That's correct—what we learn in medical school.

Senator MIKULSKI. I'm going to go to Ms. Rodgers and Ms. Eckardt, Dr. Werthamer, before I come back to you.

Ms. RODGERS. If we could go to the HMO models, for example, for a couple of minutes—take CHAMPUS, for one, that does a lot of Federal employees. When the rehab services are seeing somebody who is appropriately referred by a physician, after the first visit we must contact a person, and it is usually secretarial in nature. It isn't necessarily a nurse practitioner or anybody else associated with health care. But before we can see that patient again, we have to get written confirmation from them to continue. And at times, they ask us what we are doing and why we are doing it and come back and say this appropriate or not appropriate. They have not seen the patient. They haven't done anything but get verbal or written testimony from the provider based on an evaluation, and they are making judgments about things that we have seen, having seen the patient, that the doctor has already referred for.

Further than that, aside from delaying care, and particularly, say if it is a stroke person with a balance problem and the potential for further injury, there are significant limitations in the rehab areas for limiting equipment.

For example, one of the HMO's that does refer people within the State will provide one wheelchair in a lifetime. Now, if it is a cerebral palsy child at age 12, it obviously will outgrow child, and one wheelchair in a lifetime is inappropriate. In some cases, a wheel-

chair is not an essential piece of equipment for a quadriplegic. I'm not quite sure how they follow that logic, but that is in fact the case. In MDIPA, for example, which is a large HMO plan around the Capitol area, they will have rehabilitative services for a particular diagnosis once in a lifetime, and for an arthritic person, how do you explain to them that this is what you can do and this is what you cannot do, limited by their coverage.

Senator MIKULSKI. So what you are saying is the very nature of the bureaucracy rations care.

Ms. RODGERS. No question about it.

Senator MIKULSKI. While everybody is so up-tight about rationing care, the bureaucracy is already doing it.

Ms. RODGERS. And it leads either to falsifying documents, or—well, I shouldn't say it like that—I should say "playing the game," because it becomes a game. Somebody, much like you said, has sinusitis. Well, next time, they have an inflammation of the right sinus cavity—whatever. Their diagnosis seems to change, but we wind up seeing them for similar conditions.

Senator MIKULSKI. So—if I might assist you—you kind of jiggle the diagnostic category so that you can get them back for what they should have had, the seven visits that they should have in the first place.

Ms. RODGERS. Exactly.

Senator MIKULSKI. Ms. Eckardt, did you want to say something?

Ms. ECKARDT. Yes, I just wanted to make a comment about the clinical practice guidelines. I think moving toward outcome-based options for care based on scientific evidence is the way the movement needs to go, and I know the nurses in Maryland have participated in that, in some of those guidelines for pain management that have been an interdisciplinary model.

My second point is that nurses have been real successful in providing clinical case management—by "clinical" I mean the use of the nursing process in really looking at the total person and knowing where to direct the person as you walk them through the health care delivery system—and that has been very effective in several different models. So I have proposed that nurses prepared in utilizing the nursing process, that becomes a very viable alternative.

Senator MIKULSKI. You made several interesting points in your testimony, one of which was the role that nursing plays in public health education, not only in the delivery of what we would call traditional public health services, but public education. Many of the people who have testified today from both the business community and the insurance community have talked about the lack of awareness on the part of the patient or the consumer. And it is not malevolent, but many of them just view medicine—and part of it is our own success in this—as kind of "magic bullet" situations, where you come in at the last minute, and they want to scoot on in, and it's almost like they want you to be a "Jiffy Lube" doc or rehab specialist—pull me in, fix me up—if they've got a colon problem, it's almost like changing a muffler at Midas—and part of it is because they themselves have never been through any type of education about public health.

Many people don't even know about their own body, which is part of the problem in the school system, and so in fact when they come to the physician, there is, number one, an unrealistic expectation, and number two, the expectation of some quick fix or magic bullet, and no personal responsibility for either lifestyle change, lifestyle cooperation in the treatment process, as well as the cost—oh, well, insurance pays for it, like, oh, well, the Federal Government pays for it—like there is some tooth fairy who does everything.

Now, having gone through my own little anecdotal thing, do you see this as an important role for the nursing profession, that is, larger education on public health and particularly those things related to general lifestyle education?

Ms. ECKARDT. Very much so, and then the other part of that is the specific education that might come along. Let me share a personal example. I do inpatient psychiatric mental health nursing, and one of the things we do with our clients when they come in is teach them about the disease process and about the medication. We now have formalized modules to do that, and I think we have seen a real significant difference in the recidivism as a result of that.

One of the aspects of the nursing process is that we assess the patient; we are always in the business of assessing individuals for readiness, when they are ready to learn, whether it is crisis intervention and whether you need to be a little more directed with your approach, how much time you have to sort of play with, to be able to direct those kinds of nursing interventions that would be helpful, and education is a very real option.

We find that we are able to take into consideration the sociocultural factors as well and look at people's readiness to learn and then provide the kind of information that is available. Many times, it is informing people about how to manage the health care system—whom you go to, for what, where the providers are, whom to call for different things. So yes, I think nursing has a very significant contribution both in prevention and education and then in the management of long-term care as well.

Senator MIKULSKI. Dr. Werthamer?

Mr. WERTHAMER. I think it behooves all health care practitioners to act as ombudsman for their clients, for their patients, in order to educate them and change their lifestyle. Patients who perceive themselves as well don't see a physician for a number of years, and when they get into their 40's, they have to see the eye care practitioner because their arms aren't long enough. When they get to that point, then we can counsel them, take their blood pressure, counsel them on diabetes if they have it, and other things.

To get back to the clinical care guidelines, you know, those things are not going to be mandatory; it won't be mandatory until it becomes a State of care in the community. As you know, the Agency for Health Care Policy and Research, which is a Federal agency, is now coming up with Federal clinical care guidelines which are strictly voluntary on the part of the practitioner. They already issued two of them—one was on pain, and one was on urinary incontinence—and a third one is going to be on cataract care.

Senator MIKULSKI. We'll have to move along because our final panel is waiting to testify. I do want to go to some of the simplified things that do not involve clinical judgment and practice and whether they relate to cost containment.

We have heard much about the bureaucracy of health insurance, and there has been talk about a simplified insurance claims form. There are 1,500 different companies, and I'm sure each and every one of you has been involved filling out maybe 1,300 of them. Conversely, the insurance companies have also talked about uniform provider billing. Has that been discussed in your associations? I wonder what your thoughts are on that.

Dr. Hill.

Dr. HILL. It's part of our plan. There is a strong suggest that we have one form. We would also promote the use of electronics, an electronic form. In fact, I know that HCFA is working toward this, and they are trying to put incentives in with increased turnaround times on reimbursement. It also allows them to check more quickly for any errors. And the use of the electronic form in the physician's or other health care provider's office is going to reduce errors because they have certain formats that they can use that will help reduce the numbers of problems that are coming from that area. But overall the idea is for one form. It takes so much longer, and you have to have so many more people to walk through these forms, and when you're going from one form to another, it's like getting into a left-hand drive car, a right-hand drive car, and then a car with the steering wheel in the back seat—where do you put your feet today, and where do you put your hands? It is incomprehensible when you have a myriad of forms, and each one individual strokes their own particular insurance company. It's impossible.

Senator MIKULSKI. Dr. Nagel.

Dr. NAGEL. I would echo Dr. Hill's comments. We too endorse one form. I think it's really a very small item in the whole agenda. I think what is behind the payor and the form is really, as we talked about before, what services can and cannot be rendered. The forms can complicate things sometimes.

As far as electronic billing, I am one of the few people who still write on brown paper bags, and I have not had the problem of Medicare not paying me because of computer glitches and dumps and things like that. I think our membership would have a problem with endorsing uniform electronic billing if it evolves to that as the way things happen.

Senator MIKULSKI. But not uniform billing.

Dr. NAGEL. I'm sorry—electronic billing. Uniform billing I think would be an acceptable process.

Senator MIKULSKI. I have problems with electronic billing, too. I'm still from that generation where I'd like to have a passbook.

Dr. NAGEL. Or a brown paper bag.

Senator MIKULSKI. That's right—I don't know if it was my father's grocery store or not.

What seems to be emerging from our discussion so far is that, number one, Congress is going about it in the wrong way, that by focusing on health insurance reform, we are forgetting a couple of things, one of which, as Mr. Hillier said, is that we don't have a national health policy that then becomes the organizing principle

around what our national goals are and therefore what our core would be in terms of benefits to be provided, the minimum benefits available in a democratic society and so on. So number one, we need a policy.

No. 2, Congress making synonymous the provision of health insurance with health care, and they are not synonymous. Health insurance is a reimbursement system, but health care goes far beyond anything that we would be reimbursing. That goes to preventive health, and it even goes to things that you could challenge us on. Barbara Hill spoke about the helmet law and how people would end up in trauma care. I happen to believe that gun control is a very important public health policy. It is a very controversial issue to advocate, but yet if we spend time in the emergency rooms of many of our facilities, our doctors feel like they are in Lebanon, U.S.A. So there are a whole variety of other things going on in our society that impact upon health care. Alcoholism is a big one, leading to something called drunk driving, leading to horrendous accidents or family violence, the terrible abuse of children while you are abusing yourself, and so on.

So number one, it is a health policy, it is prevention, it is those things that impinge upon behavior, and then it is the delivery of clinical practice from a variety of modalities. But you can't talk about reimbursing for clinical practice until you really have the policy. And then the reimbursement systems would have a more rational approach, and if—two things—we could get away from "combat law," and the physicians would have the benefit of outcomes research and practice guidelines, this would go a long way to resolving these problems. I mean, if we were talking about a core, the core practice would be the traditional practices in our society, the enhancement of team membership with rehabilitation, social work. We didn't even talk about discharge planning, discharge monitoring, things that then aid the other providers to do that.

Is this right? When I go back, every Tuesday, each party has lunch, and they talk about issues and strategy. It is very informal, off-the-record, and these are the kinds of things which, based on other conversations and what you have told me today, would be the things to advocate. Am I on the right track?

Dr. NAGEL. Yes, you are, Senator. When we met several months ago, you mentioned that you had read about Dr. Todd's proposal for a national board. I think that would go a long way to beginning to have a health policy agenda established.

Senator MIKULSKI. Do you feel the absence of one as a clinician?

Dr. NAGEL. Tremendously. You talked about Desert Storm. We don't want something to happen where 1 day we don't have that "smart bomb" to go down that tube. We want that "smart bomb" to go down that tube. We just have to figure out how we can pay for it and keep everybody else happy.

Senator MIKULSKI. I think the military model is one thing—we need "smart" weapons, just like we need "smart" technology and unusual procedures. But essentially, Desert Storm was won by ordinary men and women under General Schwarzkopf's direction who were willing to do the ordinary with enthusiasm. But at the same time, you need an array of dazzling technology, well-trained people,

organized under leadership for which there is a national goal to achieve. And it all got acted out in various foxholes and cockpits.

Dr. NAGEL. It is affordable as long as we stop wasting money. And God knows, the medical profession is spending a lot of money on things that maybe it needn't do, and I'm sure all the other providers are doing it. So if we can cut out some of the waste, maybe we can spend it somewhere else.

Senator MIKULSKI. Thank you.

Camille.

Ms. WHEELER. I want to say one thing just in reference to what I have heard, particularly earlier, and that is that it's going to take time to move on this issue. I really don't think that that is necessary, nor do I think the public, at least in the conversations that I've had with the public, is really going to be that patient about all this. I think that it is very important that somebody begin to articulate a vision, which has, I think, been translated into that plan, and in my opinion, I think that vision will be taken up and carried forward.

Senator MIKULSKI. I think the public is impatient, and I think that elected officials who do not respond do not understand the dominant emotions that are prevalent in the United States of America today—anger, anger at the status quo, anger at the lethargy, anger at the glacial approach to the way we solve problems, and then fear, fear for their future, concern about jobs today, health insurance, being able to meet the day-to-day needs of their families by being able to have a job to provide for them, a safety net in case something goes wrong, and a good public school system that they can rely upon. And you either get with that program, or, I think, if you don't get with that program, the voters are throwing you out. It's not anti-incumbent; it is pro-change and pro getting back to basics.

Ms. WHEELER. I agree.

Senator MIKULSKI. Well, thank you. We'll have to move on.

I think we're doing remarkably well. As we turn to this panel, I will say that we've had six panels, 18 witnesses, since we started at 9:30, and I have really learned a lot because in addition to the formal testimony, we've tried to get some anecdotal examples beyond the technocratic approach to things.

You are our last panel, and you represent what we would call the institutional providers. Very often, you are the ones who are the most regulated and yet feel the most powerless in the system.

As you know, there are many different ideas pending on health insurance reform, and very often, you are the ones who are most targeted for "cost containment" and yet you are the ones who are also the catch-all.

So I'm going to ask Michael Bronfein to lead off, and just know that this is an atmosphere where I am trying to gather all the information I can. This is a "no-fault" environment, so please say what's on your mind, and you aren't going to be quizzed or harassed.

Michael, you are the president of NeighborCare Pharmacies. Please go ahead and give us your views.

STATEMENTS OF MICHAEL BRONFEIN, PRESIDENT, NEIGHBORCARE PHARMACIES, BALTIMORE, MD; MICHAEL MERSON, PRESIDENT, HELIX HEALTH SYSTEMS, LUTHERVILLE, MD; SANDRA MARTIN, PRESIDENT, HEALTH FACILITIES ASSOCIATION OF MARYLAND, ANNAPOLIS, MD; AND DIANE CURTIS, PRESIDENT, MARYLAND ASSOCIATION OF HOME CARE, ST. JOSEPH HOSPITAL, HOME CARE DEPARTMENT, TOWSON, MD

Mr. BRONFEIN. Yes. I'd like to bring to your attention something that has been occurring over the last four or 5 years and that in the last 24 months has escalated to a feverish pitch, and it affects everyone on this panel and really all institutional providers. I am really going to speak to two issues that are related. One relates to outpatient care, the other inpatient care, but the same thing is occurring just from different mechanisms.

About 10 years ago, prescription cards became a mechanism for payment in this country, and as a result, many people began to use their prescription drug benefit plans in an increasing manner. This led to a dramatic increase in the amount of expenditures by people, both inpatient and outpatient, for pharmaceuticals. It eventually led to organizations who were paying the bill looking for ways to contain costs. Their methodology was to approach the target which was easiest in their minds to contain, and in this case it was the pharmacy provider. So they basically unilaterally reduced the reimbursement rates that they would pay to pharmacy providers both on inpatient and outpatient, while at the same time increasing the amount of services that they were requiring.

What is important to note here is that 60 percent of the population in this country are unindemnified for prescription coverage, which means that 40 percent are covered. Of that 40 percent, 25 percent are covered under some Medicaid program. So the profile you have in this country—and by the way, this is exactly Maryland's profile—is that 60 percent of the people who go to a pharmacy or who are in a nursing home and use pharmacy services pay for it out of their pocket and either turn it in through some major medical claim or just bear the expense themselves. You have another 10 percent who are covered by the Maryland Medicaid program, and then you have 30 percent who are covered by an indemnity card of some kind, whether it is through an HMO, a third party processor plan, or a traditional insurer indemnity-type program.

What has occurred basically is that you've got cost-shifting that is taking what I would call the organized groups, the ones that are covered under some kind of indemnity plan, and those insurance companies or other parties who are involved in those kinds of practices have gone to the people they buy services from and have said, "We used to pay you $1 for this service, but starting next week, we've decided it is only worth 90 cents." Period. There is no negotiation, no discussion whatsoever.

This happens, like I said, both in inpatient and outpatient environments, and as a result the provider still has the same cost of providing the services. They haven't changed any. So the providers are shifting those costs that one party is unwilling to pay to another party. So what you find today is that the fastest growing cost

for an uninsured person or an under-insured person would be pharmacy relative to a person who is insured. So basically 60 percent of the people out there are underwriting the cost of prescription plans for the 30 percent who are willing to have the plan.

Ironically, Maryland Medicaid probably has one of the more fair reimbursement rates of any third party today and provides with a return to the provider both inpatient and outpatient that is reasonable and allows you to cover your costs of operations and make a reasonable profit.

I raise this spectrum because it really leads to something we've heard a lot about today, which is getting at the drivers of cost. Too much of what I see in all venues—managed care, HMO's—it doesn't really matter where it is—is well-intentioned people with good ideas and good plans, but unfortunately the nth degree of a piece of legislation or a rule or a new agreement isn't thought through.

A perfect example is the Pryor bill, with the "best price" provision that was supposed to lower the cost of drugs to the Federal Government for their purchase. Well, instead of doing that, it precipitated the drug companies cancelling contracts which they provided to independent providers previous to the Pryor bill which allowed those providers to provide services in nursing homes and long-term care facilities and other such places and make a reasonable return. With the Pryor bill they said, "Look, we can no longer give you these kinds of special discounts, because if we give them to you, we have to give them to other parties who may or may not buy through the same mechanism and the same efficiencies and so forth and so on, and therefore we'll cancel them all," and instead of lowering the cost to the Federal Government it just raised the cost to everybody else.

So we've got to be very sensitive to the implicit problems of trying to legislate free market issues. It seems to me that incentives have to be put in place that influence the way people buy their services or they get their services or they are paid for their services.

The Rand Corporation did a big study about 2 years ago where they had two controlled employee groups. One group paid a significant portion of their health care costs; the other was given 100 percent as an employee benefit. It was a 20-80 plan versus a 100 percent plan. The group that made a 20 percent contribution had a significantly lower total cost of health care with no discernible difference in the outcome of their general health, and the study concluded that when people were made more aware of what they were spending for and how it was being spent, that they became much more responsible for those dollars.

So I would hope that whatever course of action is taken, it leads to personal responsibility and awareness of people so they understand exactly what they are buying and what they are paying for, because right now, you have a situation—and I know this is true with drug cards, and I suspect it is true with a lot of other things—where it has really become a blind item. If I turn over my card, and I pay a $5 copay for a $50 prescription, then as far as I'm concerned, the prescription costs $5, when it really costs $50, and there may have been a drug therapy that was $3 or $6 or $10 that

could have been appropriate to start with, and had I been paying for it I may have said, "Wait a second—should I start with this, or can I start with something that's less expensive, and if this doesn't work, then go to a more progressive therapy." So I think there can be that kind of educational process.

Finally, you've got another type of cost-shifting which occurs which has to do with the way that drug companies are allowed to price drugs under Federal law. They have created a multitiered approach. For some reason, if you are in a hospital bed, the Tylenol you buy should cost you less than if you walk in off the street and buy that same Tylenol. The disparity is dramatic. You basically have a four-tier structure. Hospitals get the lowest price; then certain parts of the Government get the next highest price, which is very close; then HMO's get a price that's higher than that but less than retail, and then you go to the general retail public. Well, the majority of the drugs are purchased over-the-counter; they are not purchased through hospitals. Yet again you've got cost-shifting occurring; people who are walking in off the street are paying top dollar while people who are sitting in hospital beds or other places are paying much lower costs. So there is an inequality that is occurring here. We need be sensitive to, whatever we do legislatively or from a public policy standpoint, beginning to look at methodologies which influence the behaviors of how people spend their money, how responsible they are with it, and move away from policies which really promote cost-shifting. Just about everything I have seen in the recent past just says, look, we've got to lower this cost—fine, we'll take it off of here and pass it on to somebody else. And it's not just in pharmacy. It is in all areas, and I know that Sandy, who is also in the long-term care business, can speak to it in other ways. It seems to me not really any particular mindset, but really has to do with eliminating costs or finding out why costs are there.

In my business, if I have a cost that is escalating at an unacceptable rate, I figure out a different methodology for that particular task to get it back to where it belongs, and if I can't, then I have to find alternative uses.

Senator MIKULSKI. But you know, consumers themselves don't prescribe their own medications.

Mr. BRONFEIN. Correct.

Senator MIKULSKI. So even with the awareness, whether it is the $5 copayment—you talked about the $50 drug, in their mind it was $5, and maybe not the one that cost $27.50 instead of $50—they aren't writing that, so that is another issue.

The other thing is that pharmaceuticals made by American manufacturers and sold overseas where there are national health insurance frameworks, like the German model, sell for less in West Germany than they do in Western Maryland. And the public is cranky about that.

Mr. BRONFEIN. And they ought to be.

Senator MIKULSKI. Yes. And the rising cost—you talked about how pharmaceuticals jumped most precipitously in the last 5 years. But anyway, I know that you are at both the retail end or what I'll call a group practice—not only the individual retail stores.

What do you think that's attributable to?

Mr. BRONFEIN. A couple things. One of the problems that we have in the practice of pharmacy today is that we are the point of distribution whether it is in the nursing home or to the retail consumer, so the cost is associated with the distribution point.

If you go back and look, what you find is that the manufactured component, the drug itself, has risen at a dramatic rate, and that the amount of income that the provider who distributes it gets has actually decreased dramatically.

Senator MIKULSKI. When I raised the issue of the public being cranky, they know that the distributor, in this case the local pharmacist, is not profiteering, let's say, off of their situation.

Mr. BRONFEIN. I'm not sure I would agree with that. I think they don't discern who is making money.

Senator MIKULSKI. Well, the ones I talk to, the ones who speak to me at Broadway market, the ones who speak to me at the "Gucci" Giant off of Reisterstown Road, have a pretty distinct difference. And when we were voting on the Pryor bill to take away the Puerto Rican tax credit unless they wanted to control cost, they were very clear on where it was. Now, you may not hear it when they come in to the local pharmacy, but by and large, those American citizens who are using what I'll call lifeline medications, the seniors and disabled and so on, they know. They are really very clear. Union members are pretty clear. And they don't understand—and I have yet to get a satisfactory answer.

Mr. BRONFEIN. Do you mean as to why those costs are escalating?

Senator MIKULSKI. Yes. Why is it less in West Germany than it is in Western Maryland?

Mr. BRONFEIN. I think it's another form of cost-shifting. They are absorbing all the marketing costs and other things for the drugs in the United States, and they are selling the drugs outside the country on the marginal cost theory that says all of our fixed costs are already covered, so whatever the pill costs us to manufacture is what we're really going to sell it for.

Senator MIKULSKI. Actually, it's a topic for another conversation. I happen to believe that the issues related to the ability of pharmaceutical companies to comply with FDA, that we in this country will always insist on safety and efficacy, but we also can ensure timeliness. And very often our own Government is part of the problem, as well as our antitrust laws, as well as our capital gains approach to research as compared to making hubcaps, where there isn't the same types of risks and time line.

Do you think there ought to be a pharmaceutical component to any national health insurance framework?

Mr. BRONFEIN. I really don't. I think there ought to be an ability to pay for it, but I think there ought to be a mechanism to make sure that people understand that there is participation on their part. They should have access to it, but I think the use of a low copay card has dramatically increased the amount of waste in the system which has led to a lot of wasted money being spent.

When you go into people's homes, you'll find medicine cabinets filled with half-used prescriptions. And based on conversations I have had with many of our patients, a lot of times that card has contributed to that. I think there has to be a greater nexus be-

tween the fact that I'm buying this, and I am paying for this, versus I'm just getting it.

Senator MIKULSKI. Well, we could go on. I asked you some other questions just because I know you're going to have to leave—I'd appreciate it if you'd stay as long as you can, but if you must leave, I understand.

Mr. BRONFEIN. Thank you.

[The prepared statement of Mr. Bronfein appears in the appendix.]

Senator MIKULSKI. Mike, let's hear from you next on the Maryland Hospital Association's perspective. I'd like to, in fact, thank everyone who has participated, but really, it was the Maryland Hospital Association, working with me when I was a House member, that helped me develop the so-called all-payer system. Had I not had the Maryland Hospital Association to turn to, as well as the cost review commission that generated the kind of data that I need, I could not have advocated the all-payer system, which I think has really been a key factor in our being able to contain costs in Maryland without an artificial DRG system. I wanted to thank you for that.

Mr. MERSON. Senator, I think that's a great place to begin because you certain deserve a lot of personal credit for buying into the vision of the Maryland Hospital Association and other providers to create something as unique as the Health Services Cost Review System, which has uniquely stood Maryland residents in good and very different stead from health care consumers in the entire rest of the United States. And as part of my comments, I'd like to speak more about that.

I'd like to back up just a bit because, as you see in the paper that I have submitted to you, I am here wearing the label of the Helix Health System, something that is not a common household term in Maryland or anywhere else, like the University of Maryland or Johns Hopkins. So in the briefest of terms, I will tell you that the Helix Health System is a nonprofit holding company that operates Union Memorial and Franklin Square hospitals, and 20 other health-related entities including home care, durable medical equipment and all the other kinds of typical provider relationships that a system that aspires to be horizontally and vertically integrated to be able to serve a large, defined population needs to have as part of its responsibilities for caring for people.

I myself have been in the health care business for 25 years as a health care executive, in 10 different roles. In the last 10 years, I have spent 5 years as the CEO of Franklin Square Hospital, which is the predominant deliverer of acute health care in this immediate community, and for the last 5 years as the president and CEO of the Helix Health System.

My comments do not actually reflect those prepared for the Maryland Hospital Association; they represent my own opinions. The other hat I wear is as the chairman of the board of the Preferred Health Network of Maryland, which is licensed as an HMO but is not what one would consider to be a classical HMO. And Senator, before I forget, I would like to personally extend an invitation to you at whatever time you have available to come and "kick the tires" of the Preferred Health Network, which is right here in

Catonsville and is an incubator, funded by the Associated Group in Indiana, which is the Nation's largest Blue Cross plan and the most successful Blue Cross plan, as an incubator for fourth-generation managed care and is the only fully functional, up and operating, triple-option, flexible benefit plan in the State of Maryland, and one of the few fully operational and functioning in the United States today. We have 30,000 enrollees. Half of those enrollees are hospital employees, who certainly know the difference between good health care plans and benefit structures and those that don't allow for good quality care. So I'd love to offer you that opportunity if you can ever take the time.

Senator MIKULSKI. Do those tires kick back? [Laughter.]

Mr. MERSON. I would like to skip through most of my prepared comments and highlight a few particular themes. No. 1, I think the Federal Government, the State Government, and the private marketplace are all inextricably linked in a very Darwinian, capitalistic process that mirrors what is going on in the rest of our society today. It is very much almost a mirror image of what is happening in banking and airlines and everything else. And one can say that those things are very important to your pocketbook or airline safety, and I think our health care safety certainly deserves that level of attention and importance as well.

In my mind, we have been through generations of health care advocacy, adding benefits and programs in Medicare and Medicaid, all well-intentioned, all trying to help people, every one with a whole series of unanticipated effects on society that really have a massive transformation as well as a cost effect.

Most recently, the Federal Government, in my estimation, by enacting the Prospective Payment System, was really a budget-driven action that says we're going to look out for number one and take care of our own financial liability. What that does is have the indirect effect of furthering this Darwinian process by extricating Medicare to a defined financial level and then letting everybody else fight over all the rest of it.

Now, as I said, Maryland is excluded from this Darwinian process thanks to people like yourself, but the rest of the country is in absolute turmoil in my estimation—and I spend a good bit of my time in other parts of the country with my colleagues.

I think it is essential that we provide a stable financing mechanism or mechanisms for Americans to feel safe and secure about having access to good, basic health care, and it certainly should be on a nondiscriminatory basis.

The rest of my comments are going to focus on four main areas—the American society and the consumer; health care providers, their construct and their use of technology; the current inequity in insurance, and the benefits of an all-payor system where we began.

Senator MIKULSKI. Can you do that in five minutes?

Mr. MERSON. Real quick. I think, as has been stated by many of the providers, we have to look at demand before you can just start to look at the supply or even the insurance financing mechanism. People spoke about rates of homicide, suicide, and all kinds of things that are not unique to this society, but may consume costs at a highly disproportionate share.

The other thing that I'd like to point to is what we call "futile care," which is the demand to kind of live forever irrespective of whether or not all those units of cost that people demand be administered to them have any value whatsoever. They are in the tens and tens and tens of billions of dollars that go on forever.

I could talk about innumerable examples of waste, and the bottom line that I would like to leave you with is that those people who believe that we should be rationing now—in my estimation, rationing before curing waste is really immoral.

Senator MIKULSKI. I think that's a great point.

Mr. MERSON. I believe that with great sincerity.

The second basic issue is health care providers and their use of technology. People scream about the overuse of technology and so on, but nonetheless it has produced awesome results. The ability to add to life nonetheless costs a great deal of money, and that's what we're doing; we're adding to life and adding to more demands on the system as we extend life. But we should not stop the revolution of technology, particularly the biological revolution that is underway. More money should be invested in it, because the basic economic paradigm that's wrong in health care that has worked in every other segment of the economy is that you replace the human cost—the farmer plowing the trenches by himself or herself—with mechanization that allows much greater productivity. We are still doing personal piecework, adding technology cost on top of people cost, with no substitution factor. The technology and biological revolutions will replace that fundamental mis-economic equation that we currently have and will get it into a fundamentally successful economic model over time.

I will support all the comments that have been made about developing clinical pathways and protocols. I think we are far enough along to begin that process, and information systems technology can integrate and link that in the future very nicely.

I'm going to skip over an awful lot of my written testimony and talk about the all-payor system.

Senator MIKULSKI. The entire statement will be included in the record, including all the materials you submitted.

Mr. MERSON. Thank you.

Again, the all-payor system in Maryland has driven hospital costs down from 30 percent above the national average in 1974 to now 10 percent below the national average, and in support of that I brought the Maryland Hospital Association's latest brochure, which I will give you afterwards and would like to enter into the record, which graphs that 17-year period of time and all of its economic ratios for your perusal. But the outcome is that we have proven that hospital costs can be contained, that the public can maintain good access to medical care in all of Maryland's hospitals without any serious disruption.

The other point that I'd like to make is that every other insurance and financing proposal, single-payer, tax reform or whatever, without the basic elements of fairness and equitable payment across all payers, is fundamentally flawed. If you don't solve that problem first, just as Mr. Bronfein indicated, cost-shifting will be inherent in any other solution. I would encourage a very careful ex-

amination of the underpinnings of any all-payer system as a prototype for further reform.

The other point I wanted to make is that I would examine very carefully on a Federal level the misuse of the gross national product. The gross national product is not, as has been reflected, the cost of health care. It is the cost of all goods and services in that measured sector of the economy, and it may be vast different from country to country, and I think that in and of itself bears Federal scrutiny.

Comparing Canada, Norway and Sweden to the United States in my mind is like comparing a Subaru to a Mercedes and saying that they are the same.

And finally, just so that everyone knows, the Maryland Senate has already passed uniform billing legislation that has been enacted. The models will be UB-82 billing forms for hospitals, and they have already passed legislation indicating that the HCFA 1500 form or something like it will be used for all other providers. So the discussion about that, at least for Maryland, has already been pretty well solved.

I'm sorry for taking more time than I was allotted.

[The prepared statement of Mr. Merson appears in the appendix.]

Senator MIKULSKI. Thank you very much.

OK, Sandy.

Ms. MARTIN. Hi. My name is Sandra Martin. I am a registered nurse and also a licensed nursing home administrator. I have been involved with a family-run nursing home that my mother and father have owned and run for 30 years, so I basically grew up around it, and I am currently the first nurse and first woman president of Health Facilities Association of Maryland.

Rather than go through the testimony that you have before you, there are a couple of things that I think we need to make points about in terms of long-term care. The most recent health plan that just came out for the State of Maryland has defined long-term care to include care for the functionally impaired. Many people think of long-term care as only care for the aged who are disabled and need custodial-type care. That is not real. That is not what exists out there in what you term nursing homes today.

Nursing homes today have intensive rehab services; they are taking care of AIDS and communicable disease patients; they have mentally ill and mentally retarded patients who have physical needs that now require more in-depth care. The State is planning this summer to pass regulations so that nursing homes can care for ventilator-dependent patients, head trauma patients and medically complex patients as well as Alzheimer's, just to name a few of the different complexities that we are caring for currently in the State of Maryland.

As you look throughout the Nation, you will find long-term care facilities are also taking care of children and all age populations—long-term care, not care of the elderly. So I think that is important to understand because as people talk about medical coverage and new reform, the words "long-term care" seem not to appear there, and most people are trying to avoid payment for long-term care in their reform. If we do that, we will not just be ignoring the elderly

and their needs, but we will be ignoring long-term care for all ages, and I think that's an important part to keep in the forefront.

Dr. Tyler, who is with MedChi and is on the medical directors committee, has defined care for long-term care facilities as "maintenance care, rehabilitation care, and terminal care," not in the terms of a 6 months' terminal, but terminal in that their care will no longer go forward or stay the same, but will go on and slide and will be providing for the needs of the terminally ill person. That is the kind of care that is existing now in facilities in Maryland.

Maryland, as you hear everyone speak of, is very innovative and always has been with their hospitals and their all-payer system. In addition to that, the nursing homes and nursing facilities in Maryland have been under a case-mix reimbursement system since 1985. When the system was designed, it was designed for certain goals to be met, and those goals were met through a proper reimbursement system that first decided what it wanted to accomplish and then figured out how to reimburse it. Through that type of mechanism we were able to meet the needs of the medical community.

Because we have been in a reimbursement system over this time and also have been affected by the economy, we recently completed a study that looked at the payment for nursing facilities in 1989, and we found that 65 percent of our costs in nursing homes were not covered. Unfortunately, we still continue to care for the same types of people, and we also often have to resort to cost-shifting because we have the populations in our facility.

We then asked the State to begin to look at the system under which we were reimbursed, and rather than dealing with it from a reimbursement issue, because each year it was cut simply because there weren't sufficient finances—and this is what we have learned from this, that that's not the way to deal with systems—we were cut, and no sense was made of it; there just wasn't enough money. Now we have been able to sit down with the State and ask them to once again define their goals—what is it they want us to be, what do they want us to look like, what kind of people do they want us to care for—and from that, then design how you are going to pay for that system. I think that's extremely important.

We have also done a great deal of data collection, and we have that available if you would like to look at that.

Perhaps our Maryland Delegation needs to think about the fact that Maryland may be an excellent model for the whole United States both in terms of their long-term care coverages as well as their hospital coverages, and maybe a trial could be done in the State without a great deal of difficulty since we have these systems already in place and have had them in place for several years. It may be a starting point.

Long-term care has been able to adapt to the changes. Fifteen years ago, if you walked into a nursing facility, it would not look like it does today. We have been able to adapt by educating those people who are in our facilities and by bringing in professionals to teach and train them. Not always is it necessary to bring in additional professionals, but rather, to have the educational portion paid for so that you can upgrade your people who are already pro-

viding care. That is another way to have cost savings, is to bring in the educational people and provide that for your current staff.

I'm just trying to think if I left anything out.

Senator MIKULSKI. I'll tell you what. While you think about it, why don't you just wrap up, and then I'll go to Ms. Curtis, and then we'll have a chance for a little dialogue in the question period.

Ms. MARTIN. OK. Basically, those are the most important issues.

[The prepared statement of Ms. Martin appears in the appendix.]

Senator MIKULSKI. Thank you.

Ms. Curtis.

Ms. CURTIS. Thank you, Senator Mikulski.

I like some of the others want to avoid going over the written testimony that I have given you and to just summarize.

Senator MIKULSKI. Thank you. You are our wrap-up speaker.

Ms. CURTIS. Home care has been around for quite a while, but I don't think much notice has been given to it until the last 10 years, when there was quite a growth, which brought quite a bit of attention from HCFA to the home care industry, which has been quite a bit of problem for home care agencies. We have had to go to task with HCFA quite a bit over some of the issues.

I think one of the things that HCFA failed to take into account when they came up with the Prospective Payment System was that these patients who are leaving hospitals much earlier and much sicker were going to have to enter other delivery aspects of the health care system. So there was quite a bit of attention given, and there was a move to be quite restrictive with the home care benefit.

But all in all, we are still a very small percentage of the Medicare health care dollar. We are approximately 2.48. We service a small portion of the Medicare population, but what we are finding is that those individuals are very, very sick. And I think I would caution any changes in our system to look at how Medicare has reacted to systems that try to curtail costs without looking at the quality and the services that our beneficiaries, our constituents need.

There is very little hard data on home care, so I did take some information from the home care program at Saint Joe's and started looking at changes. What I have seen is that since 1989, our visits have increased from 13.2 visits per patient to, for the first half of this year, 19.6. I think this reflects the sicker patient and the more elderly patient. We have more and more patients coming out who need daily and even twice-a-day services.

We have seen a change in the age of our patients to where, in 1988, 27 percent of our patients were over 85, and we now have over 21 percent. And we have 62 percent over the age of 75. So we are seeing a much sicker population and a much older population.

I think one of the biggest problems we have, and it goes into the need for long-term care, because as home health agencies we are reimbursed for skilled care, but not custodial care. I would say on the average of once a week, we have to make a referral to adult protective services—not because these elderly people are being abused or neglected, but because there is inadequate care in the home. It is a 97 year-old cared for by a 98 year-old, or a 97 year-old cared for by a 72 year-old, and there is no funding. If they are fortunate enough to have savings, whether it is in-home care or

nursing home care, $35,000 to $40,000 a year. And then if it is a spouse—and I'm sure this has been talked about this morning—if it is a spouse, and they go into a nursing home with Medicaid, they are left just about indigent and unable to maintain their home and have to look for alternative living accommodations. So it is not surprising that they are resistant to the solutions of remaining in their homes.

The programs that are availability in the community are not adequately funded; they tend to be more of a frustration than a solution—gateway programs, Office on Aging, Department of Social Services—with waiting lists that are months long.

Senator MIKULSKI. Waiting lists for what?

Ms. CURTIS. For in-home personal care assistance. This is what so many of our chronically ill and elderly need. There is skilled care available through our insurance companies, whether it be Medicaid, Medicare, or other insurance companies. What is lacking is long-term care, custodial, nonskilled care. If you go to a for-profit or private pay agency, the minimum generally is $8 an hour, and if members of the family are gone from the house ten hours a day, working, it is $80 a day, which comes to about $30,000, $35,000 a year, out of pocket.

Senator MIKULSKI. Which is the same as being in your facility.

Ms. CURTIS. In a nursing home.

Senator MIKULSKI. Unless you say it's mom living with Dick and Jane—and at least they know that if mom were with you or one of the members of your association, there would be safety, there would be supervision, there would be meals, and so on.

Ms. CURTIS. Right, and you don't have to worry about the person that you've hired not showing up, and then the caregiver has to take off work or try to get a substitute. So there are a lot of problems out there. I see my staff get very frustrated. I am always amazed that they can go out and provide such wonderful care and not get totally burned out, because they have to deal with so many social problems. The medical problems, we can deal with, but it is the social and economic problems that we're seeing.

When I went to work at Saint Joseph's about 7 years ago, we had to change our forms because almost all of our patients went into our statistical gathering of over 65, because we weren't even capturing that kind of data, and we're seeing the patients getting older and older.

Senator MIKULSKI. Do you want to come to your recommendations now, because I want to come back and ask you some questions. I think that gives us some pretty good pictures.

Ms. CURTIS. I have case examples in my testimony.

Senator MIKULSKI. Yes, I saw them, and we'll go over them more carefully.

Ms. CURTIS. I think what we really need to look at is not rationing; we have to look at regulations. I don't think we solve the problem by over-regulating and trying to limit services. The paperwork burden is immense, more so probably for home care than anyone else—probably 35 percent of our cost is involved with paperwork and administration. And certainly, we have to look at tax incentives, some very serious tax incentives, for alternative lifestyles, whether it be group homes or tax incentives for living centers and

for families who want to take care of these people—I mean substantial, not just that you get $2,100 because you now have another dependent in the home—because I don't see that institutional care is going to be a total solution. Certainly home care can be somewhat effective, but not in a lot of cases. So I think there is a big problem with that segment of our country when we are trying to come up with health care benefits. And I didn't even touch on the younger population.

[The prepared statement of Ms. Curtis appears in the appendix.]

Senator MIKULSKI. Well, thank you very much for your testimony.

What we have here is essentially a continuum of care represented by the three of you here, both the provider of acute care; home health care is supposed to be an intermediary step after someone is discharged from a Maryland Hospital Association facility, perhaps, or discharged from there into one of the nursing home facilities for rehabilitation and followed up. But essentially, you are the triad around which so much of the elderly population or, if not elderly, the kinds of people that you have described, Ms. Curtis, and that you described, Ms. Martin.

Now, in all of the debate that is going on in health insurance reform, these two—you, Ms. Martin, and you, Ms. Curtis—are left out. And yet, Mr. Merson, you can't really run your hospital without these two—am I right?

Mr. MERSON. Correct.

Senator MIKULSKI. I mean, essentially, at a point of discharge for certain of your population, you must turn to them, because this whole idea of people leaving with very white teeth and beautifully-set hair, walking into a loving family is only a portion——

Mr. MERSON. That's a myth.

Senator MIKULSKI [continuing]. It's a myth—particularly for the older or the more seriously injured or the more seriously ill, where you've done what you can do there.

Mr. MERSON. All the incentives in the acute hospital stay are to in effect get the patient out as soon as possible, which implies that there have to be other components of a continuum of care that are ready, willing and able in terms of accessibility to expedite that kind of discharge and ensure good continuity of care, appropriate safety, etc.

Senator MIKULSKI. I know you have reviewed the three basic frameworks for health insurance reform—the Bush tax thing, "pay or play," and the single-payer. Is it your observation that by the very nature of many of their cost containment mechanisms, it will only intensify shortening of stays and the discharge of patients—and presume we're not part of the all-payer system—in other words, by the very nature of reforming the system, we are going to break other parts of it.

Mr. MERSON. I think it's the kind of thing where the genie is out of the bottle, and once it's out for any single payer, it's out for all. Wherever you go in America, the incentives are basically the same, that is, to in effect limit hospitalization on the front end or the back end—and it doesn't make any difference whether it is Medicare, Medicaid, MediCal, Aetna, Travelers, whether they are in an indemnity product or a managed care product, HMO, PPO, or any-

thing else—those are the essential elements and economic incentives or drivers in the entire system at this point in time. And with that is bringing both good, in that it is bringing more efficiency, tougher management, more rigorous approaches, working with physicians and nurses as teams to shape care protocols, critical pathways to expedite patient treatment, not forsaking safety. Many of these things are very positive, and they are in stark contrast to how acute hospital care is delivered in most of the rest of the country where lengths of stay are much longer, in many ways the way care was delivered in the Forties and Fifties in the United States.

Senator MIKULSKI. What do you think should be the core elements of a health insurance program?

Mr. MERSON. I think the core elements have to be a good, balanced set of benefits—the insurance policy itself. But within that context I think there have to be strong incentives because of the consuming nature of the American public, strong incentives for people to be channelled toward——

Senator MIKULSKI. Do you think we have an insatiable appetite for everything, including health services?

Mr. MERSON. We do have an insatiable appetite. We have an absolutely insatiable appetite for health services, life extension, life expansion. But I think Dr. Hill is essentially correct that we've got this vast disproportion of the main caregivers. Patients should be, through their health insurance product, channelled into a primary care or incentivized to pick a primary care caregiver who then is responsible for the management of that patient's care. But on the other hand, I think people should be able to use their own cash out-of-pocket resources to buy whatever they want as Americans, as long as it doesn't come out of the Federal or the State tax dollar or out of somebody else's health insurance premium or the employer. If I make it and save it, I believe I ought to be able to use it. But I think I should be channelled or incentivized into that kind of structure that then controls and manages my care and resources. That physician provider then needs to be incentivized to do the best job all the time—not rationing care as capitation does, but not overpaying as fee-for-service reimbursement does.

These models that I am describing are now being developed and are coming into the marketplace and, in my estimation, really have hope.

Senator MIKULSKI. And they will. Earlier we heard from the business community. Ms. Morrison is one of those who help the business community find insurance products. Here is a question for you. You talk to a small business, and they have had a catastrophic situation, one that is not behavioral—the need for a bone marrow transplant, or the need for a premature baby who comes to St. Joe's—and I have toured your very fine, beautiful facility—and all of a sudden, that's about $100,000—is that a month, or is that a week, now——

Ms. CURTIS. I hope it's a month and not a week.

Senator MIKULSKI. But all of a sudden, it's $100,000, and the baby will thrive and survive, but it needs careful monitoring.

All of a sudden, if you've got a business of ten people, zing, it's wiped out, not just for the family. Do you think there ought to be a national catastrophic pool that would essentially take care of

these things that private insurance, if you keep it at small groups or community risks, that would just really break it?

Mr. MERSON. One way or the other, whether it be——

Senator MIKULSKI. People talk about, number one, those things associated with aging, and we'll come back to that, or a chronic and progressive situation. Those are what you are engaged with. Then there is the normal acute care like gall bladder surgery. I mean, I've got the longest living gall bladder in my family, and I am ripe for it. But under Zucker-Bailey's technique now, I can be in and out, and my insurance will cover that. OK. But when we then get to these others, extraordinarily expensive prolonged care that really must be dealt with in an acute care facility and in many probabilities will require the complementary team after discharge, do you think there has to be a national pool for that, or do you think that should stay with the private insurance system?

Mr. MERSON. I think either way can work. I believe it has to be an essential element. There are several ways—the basic problem is getting enough mass to be able to break that liability in an insurance product. The smaller the mass, the more difficult the ability to rate it and charge for it. So whatever vehicle is chosen, it's just a matter of developing an economic model that gets enough mass into then what can be purchased by anyone as an excess liability insurance premium, whether it is purchased by the State and then sold back to health insurance plans, purchased by the Federal Government, sold back to the States and then resold back to private insurers. There are an infinite number of ways to do it. It's just a matter of defining how one wants to aggregate the mass, associate a cost to it, and then levy a premium that then can be passed on. But I think it is an essential element that Americans deserve to be indemnified from.

Senator MIKULSKI. I want to come back to what you find, Ms. Curtis, and then to you, Ms. Martin. Ms. Curtis, what you're saying is that when someone is discharged from St. Joe's or an acute care facility, you are licensed to provide home health care. And if I could summarize your testimony, what you are finding is that in conjunction with the home health needs being met, often they are of short duration; it is the need for home care, and for that, there isn't a wink available.

Ms. CURTIS. There is none at all.

Senator MIKULSKI. And because of the lack of home care, they then end up back in acute care. For example, looking at your examples, the diabetic who, because of improper bathing—just very modest things in the home—then develops infections or goes into diabetic arrest because they didn't eat right.

Ms. CURTIS. And one of the problems even with a payer system like Medicare is that they will not cover preventive care. In fact, a typical example is——

Senator MIKULSKI. There is no preventive home health care?

Ms. CURTIS. It's an exclusion in Medicare home health. They will not pay for preventive services. So we find instances where we no longer have a reimbursement system because the bedsore isn't deep enough. But if the bedsore gets deep enough, we can go in once a day, twice a day, we can get very expensive beds. But once it gets to a certain stage where it is healing, we no longer get reimbursed.

So we either had to provide a free service, a charge, or we have to wait and pull out and let it get bad again. It makes no sense. There is no sense to the system.

Senator MIKULSKI. I want to ask you about discharge if I could, Mr. Merson, while we're engaged in this conversation. Are you adequately reimbursed for discharge planning and discharge monitoring?

Mr. MERSON. Yes, under the Maryland all-payer system, absolutely.

Senator MIKULSKI. And what about nationally, as your association works? So it's not only the planning which is the right plan, often a home visit and so on, but then after that person is discharged. At times, particularly after, say, your two Medicare visits or whatever have expired, that which is certified for skilled care—is there a plan for discharge monitoring, particularly for what we would call high-risk situations or medium-risk?

Mr. MERSON. To the best of my knowledge within hospitals, whether it be Maryland or elsewhere, once the patient leaves the hospital, unless the hospital has its own home care agency, the hospital in effect ceases its liability when the patient walks out the door.

Senator MIKULSKI. I understand.

Mr. MERSON. They have a responsibility to assure some continuum.

Ms. MARTIN. Could I just add one point there which is very important? Within a nursing home, as we begin to get more and more technical skills and technical patients, and we receive them much sicker from the hospitals—I have received central lines, I have received people on Gumco suction, and so on and so forth, i.v., etc. If I—I, a nursing home—had better accessibility to the resources that the hospital possesses, and we could share those resources, it would be much less costly for us to take those patients and gain the expertise. But that is not the way it works right now. The hospital is saying, "Take this patient," and I am saying, "No, wait a minute—you don't understand—I haven't had Gumco suction for 15 years." One, I've got to figure out where I'm going to rent the piece of equipment. I can't get it from you because you won't do that for me, so I have to go somewhere else. And then I have to figure out how do I do it again.

Senator MIKULSKI. And do the regs prevent that?

Ms. MARTIN. Do the regs prevent it?

Senator MIKULSKI. No; why can't you do that?

Ms. MARTIN. There is no mechanism to correlate hospitals and nursing homes to create that united care for the patient. It really does not exist.

Senator MIKULSKI. Is it a payment or a reimbursement issue? Is it a regulation issue? Or is it just the way we do business?

Mr. MERSON. I think it's a byproduct of something, again, that really was not anticipated as the rigorous pressure is put on hospitals to discharge patients earlier and earlier and sicker and sicker. It is just a byproduct that has transferred a certain slice of what used to be taken care of in the hospital into the nursing home or into the home care situation, for which people didn't anticipate,

weren't prepared, and are underfinanced to be able to gear up to accept that level of responsibility.

Senator MIKULSKI. Nor are they reimbursed to provide that.

Mr. MERSON. That's right.

Ms. MARTIN. It also expands into mental health. We often receive patients who have been seen as at a level that we could care for, and all of a sudden they go into a critical or acute State of mental illness, and we have a very difficult time getting services for them, either within our own facility, because the reimbursement is something like $8 for a psychiatrist to come out and review the patient—well, forget it; it just doesn't happen for Medicaid. And often when we send them to the hospital, they are medicated and sent back. Apparently, it is difficult for them to re-accept them as a new admission, so there we sit with a patient who is very dangerous and no resources to go to.

We could probably do the care, but we can't get to the resources to help us.

Senator MIKULSKI. Ms. Curtis, did you want to comment?

Ms. CURTIS. I always thought one of the frustrations is that Medicare will not allow a Medicare-certified home health agency to provide service to a patient in a nursing home. Yet I think that could be part of the solution to some of the dilemmas that Sandra has because in home care, we are doing i.v.s, we are doing the equipment, we are doing that level—but if that patient needs to be in the nursing home, whether Medicare is paying for it or not, if they are even private pay, we will not get reimbursed for our service to go in and assist the nursing home with that level of care.

Senator MIKULSKI. Here is one of the issues now in terms of the Rockefeller bill, which I have cosponsored, which will be different from the national health insurance. You see, nobody wanted to take on long-term care—you are exactly right—because it seemed like, first of all, most of the situations are chronic, and they are progressive, and they weren't sure how to get a hold on it, and then you get into the cost—I won't go through all the debate, but you can anticipate it.

Now, Senator Rockefeller has used the Pepper Commission Report to introduce his long-term care reimbursement system. It provides for some continuity of care. However, it doesn't deal well with reimbursement. And I told Senator Rockefeller, I'll go on it, but I've got real problems with this.

First of all, the reimbursement for you is really only at inflation plus what you would do for capital facilities; isn't that right, Phyllis? What is the reimbursement in the Rockefeller?

Ms. ALBRITTON. Two sets of payments, one for patient care and one for capital investment.

Ms. CURTIS. Is it based on the care the patient receives, in other words, the case mix, if you need heavy care versus——

Ms. ALBRITTON. Yes, it is case mix adjusted.

Ms. CURTIS. Does it go beyond activities of daily living and get into these more specific areas, such as——

Senator MIKULSKI. I think it's screwed up, OK? You can go through your criteria. I know that your executive director is Ms. Wilzack, who really developed the innovative reimbursement system for the State of Maryland. What would be most useful as we

move ahead in the debate on long-term care is if I could have the description of the Maryland reimbursement system from your perspective. I will get a description of it from the Department of Health, but from the person who must provide that care, it would be very useful to know how this system works and, because of the shrinking Medicaid budget, the implications of this.

We all read and were horrified about the man who was taken by his daughter out of a long-term care facility and abandoned. I maintain that that man was abandoned by his own United States Government. That in no way excuses family or personal responsibility. I am a very strong advocate of that. But in this situation family responsibility was going to lead to family bankruptcy. And for someone to do that to their own father either implies a callousness or a level of desperation. We don't have a national system for long-term care. We have now Medicaid as the safety net. And we are paying for it. Everybody says we don't want a payroll tax, but the cost of Medicaid being passed on to the business community of all types by essentially a payroll tax, whether they call it that or not. So that's a way of saying I would like to see how the Maryland system is working, and also how the Medicaid cuts are affecting your ability to provide safe, satisfactory and clinically appropriate long-term care, as well as your patient distribution.

That would also go for you, Ms. Curtis, because I think it's the same approach.

Now, let's talk about this custodial care, and then I'm going to wrap up. Ironically, I have got to be at a Johns Hopkins Public Health 75th Anniversary.

We talk about care in the home apart from, say, the skilled care as unskilled care. Do you really think that's unskilled care?

Ms. CURTIS. No, but I think we've gotten brainwashed by our third party insurers, whether it be Medicare or the other insurers. I think it's unrealistic to expect families without any kind of assistance or training to do such things as enemas and eyedrops and how to give a bath and how to take care of a bedsore and how to feed and how to give medicines. These are not things that a layperson automatically knows.

Senator MIKULSKI. Ms. Curtis, has the home health care community thought about this—here is a paradox that we are in, and that I am presenting to you. No. 1, my first concern would be someone who was intellectually and ethically competent to be in the home to provide care for activities of daily living, because I would be concerned about abuse. I think we have all heard those stories, and I'm sure you hear them, where they bring someone in, and it's a horror story, or their boyfriend comes around and they are robbed, or any number of terrible things. So that means training, that means licensing or certification, that means bonding, and so on. That then implies a level of cost which then takes us from $8 to $15 an hour; am I correct?

Ms. CURTIS. You're right.

Senator MIKULSKI. Is there a way, or has the association thought about how people can do this so that we meet the concerns about safety and adequacy without having an enormous cost—or is it just impossible?

Ms. CURTIS. We have struggled, and I have to say that I think it is probably impossible to keep the costs down. We have registries, like employment——

Senator MIKULSKI. I know, and some are great, and some are shaky.

Ms. CURTIS. Yes. There really are no regulations controlling the care and the people to any extent. And they might be $6, $6.50 an hour. Then your next level is an agency that is licensed, so they are employees, they do have workmen's comp and so forth—but now you're up to $8.50, $9.00, $10.00, $12.00, $13.00 an hour. And as far as the training, you have to look at what you're paying for. You are taking a nonskilled person and paying them not much more than minimum wage. So you cannot expect them to have the kind of commitment you would of a nurse or a physical therapist. They tend to be somewhat transient themselves.

And one thing—I don't know why insurance companies never want to try it—they always exclude family from taking care of the person. It is always an exclusion in the contract, whether it be the Medicaid personal care program where it can't be immediate family, or whether it is major medical. Why not? I mean, where are you going to get better care than perhaps from a family member if you pay them the same amount of money you'd pay somebody off the street? It has never been looked at. For some reason, there is an attitude that if it's a family member, they're cheating, they're just taking the money and not doing anything. But I see it is totally different when we're in the home. There is a real concern, but with the economy, the daughter or grand-daughter, whoever, needs to be out there working. So if she can work at all, all she's doing is paying for that person to come into the home and take care of her mother or grandmother.

Senator MIKULSKI. We see that also with the care of a handicapped child at home.

Ms. CURTIS. That's right, whether it be the elderly or the chronically ill.

Senator MIKULSKI. We heard from a mother today who kicked off our hearing, Mrs. Donna Welsh of Dundalk, whose son has congestive heart disease. He is able to go to school and so on, but he requires monitoring, so they are a single-income family, and also there needs to be the safety net.

But there is no pro-family help there for that, and it will also ultimately affect Mrs. Welsh's Social Security—and I could go on.

I think that's an excellent point.

Well, there are many other issues that we could go into. I think the debate on long-term care is going to take longer than the initial health insurance framework. But this is not the only conversation we're going to have. I have learned a lot. And before I close, is there any final wrap-up statement that any of you would like to make?

[No response.]

Senator MIKULSKI. I want to thank you all. We've gone through six panels and about 23 witnesses, and I'm going to get a quiz. Senator Kennedy is going to call me in 15 minutes. But this is an official hearing of the U.S. Senate, and your testimony is going to be included as well as our discussion.

I want to thank you for what you are doing. When I hear about the complexities of reimbursement and the obstacles that are placed in your path to do your mission, it is amazing to me that anyone wants to continue to do it, really, and I say that in the most sincere way. The complexity of the delivery of patient care is, in and of itself, extraordinarily challenging and difficult, and then when you go out and have to deal with this whole other system, it must be extraordinarily frustrating. So I think one of the core elements must be simplification and minimum bureaucracy that you then have to contend with, as well as adequate reimbursement.

Thank you all very much.

[Additional material supplied for the record follows:]

K. Allen

FLOOR COVERING RESOURCES
4212 Howard Avenue
Kensington, Maryland 20895
(301) 897-9226

Statement of Karin Allen
Before the U.S. Senate
Labor and Human Resources Committee

April 23, 1992

Mr. Chairman and Members of the Committee:

I thank you for the opportunity to speak to you on behalf of Floor Covering Resources, a small business located in Kensington, Maryland.

My name is Karin Allen, and I would like to ask Congress to establish a universal single-payer health care system for all American citizens.

I have worked for Floor Covering Resources in a full-time position since January 1984, and I would like to tell you about this company's experience with group health insurance, which I am sure is the same experience for thousands of small Maryland businesses.

In 1987, this company bought small group major medical health insurance from Blue Cross and Blue Shield of the National Capital Area. The policy has a $1 million life-time benefit for each group member. Insurance coverage became effective on November 1, 1987.

Our group had three participants:

	AGE	1987 COVERAGE RATE
Karin Allen	47	$168.92
Elizabeth Allen	24	77.96
Michael Brandland	24	77.96
TOTAL MONTHLY PREMIUMS		$324.84

Elizabeth Allen is my daughter. She was a full-time college student in 1987, thus eligible for dependent coverage.

In July 1988, this company received a letter from Blue Cross and Blue Shield informing us that beginning in October 1988, any pre-existing conditions of new employees and their dependents would be permanently excluded from coverage.

According to a spokesperson at the Maryland State Department of Licensing and Regulation Insurance Division, this benefit exclusion was new and was being implimented throughout the insurance industry. The prime targets of this change were small companies with fewer than 9 employees.

When Blue Cross and Blue Shield renewed our contract on November 1, 1988, total monthly premiums increased to $400.92

	AGE	1988 COVERAGE RATE
Karin Allen	48	$208.48
Elizabeth Allen	25	96.22
Michael Brandland	25	96.22
TOTAL MONTHLY PREMIUMS		$400.92

In December 1988, I had emergency surgery for a herniated disk at George Washington University Hospital, and Blue Cross and Blue Shield promptly paid almost all my medical bills, around $19,000.

In August 1989, Blue Cross and Blue Shield informed us that they felt it necessary to raise our rates again. Beginning November 1, 1989, monthly premiums increased by 70 percent. The insurer explained that "the adjustment is based in part on your group's claims experience as well as the collective experience of other local groups similar in size to yours."

The 70 percent rate increase was imposed on the entire group.

	AGE	1989 COVERAGE RATE
Karin Allen	49	$379.96
Elizabeth Allen	26	181.74
Michael Brandland	26	181.74
TOTAL MONTHLY PREMIUMS		$743.44

When I lodged a complaint about the steep rate increase with the Maryland State insurance commissioner, the insurer stated that because of my claim, our group's claims to premium ratio was greater than 71 percent, and Floor Covering Resources was classified as a high risk group.

The Maryland Stateinsurance commissioner's office assured me that Blue Cross and Blue Shield was not in violation of the state insurance code.

Small businesses like the one I work for now face strict medical underwriting. Our insurance company demands detailed information from new employees and their dependents covering over 40 medical conditions. This practice is more than outrageous, it is humiliating.

Floor Covering Resources hired a new sales person in July, 1991. As the group administrator I filled out the necessary forms immediately, and my new coworker submitted the required health questionnaire to Blue Cross and Blue Shield. It took the insurance company over 3 months to let my coworker know that they had not received sufficient medical information from her physicians and that they had closed her file.

My daughter lost her job with Demar Corporation in Rockville, Maryland over one year ago. She had to cancel her health insurance coverage through Lincoln National because she could not afford the $160 monthly Cobra payments. She was fortunate to find work on the temporary staff of a large Bethesda based corporation. Even though she has worked 40 hours a week for the past 9 months, she does not qualify for medical benefits. My daughter receives her "medical care" at Planned Parenthood. If my daughter and I lived in Canada or any other industrialized country in the world, we would not suffer these perpetual anxieties about health insurance. It seems unbelievable that our current health care system penalizes people like my coworker and I for having an on-going medical problem.

As of November 1, 1991, my premium for single coverage has soared to $443 per month. Over one dozen health insurers have refused coverage because of my back problem. My current $443 a month health insurance premium represents a 35 percent payroll tax and 50 percent of my take-home pay.

Many clients of this small business are having difficulties holding on to their health insurance policies because of rising costs.

I am afraid that I will not have health insurance much longer. My employer will soon retire and another employer may not offer medical benefits. I can assure you that I will not be able to afford a conversion policy from Blue Cross and Blue Shield. Their standard non-group policy without major medical offers very poor coverage, and it costs over $200 per month.

Please enact a universal health care plan which will provide access to comprehensive, quality health care for all American citizens.

Thank you very much for your attention.

Sincerely,

Karin Allen

Karin Allen

Blue Cross
and
Blue Shield
of the National Capital Area

550 12th Street, S.W.
Washington, D.C. 20065
202 479-8000

Chartered by the Congress of the United States

July, 1988

MR. ROGER FLAHERTY
FLOOR COVERING RESOURCES
4811-B BETHESDA AVE.
BETHESDA MD 20814

Re: Letter of Amendment Regarding
Medical Underwriting of New
Participants Effective October 1, 1988
Group Contract #: A819

Dear MR. FLAHERTY:

No doubt you are aware of the steadily increasing costs of health care coverage offered by all health insurance companies, including Blue Cross and Blue Shield of the National Capital Area (BCBSNCA). Because the rates charged by BCBSNCA must be sufficient to cover the claims expense that we incur on behalf of enrolled employees and their dependents, it is to our mutual advantage for us to take steps to slow the increase in rates. One important way to do that is to reduce the claims expense by better controlling underwriting risks.

At BCBSNCA, we have already taken several positive measures to reduce claims expense. As you may recall, some of them are:

Minimizing inappropriate services and the overuse of services by adding our "Managed Care Program" to all of our community-rated groups (effective during 1987).

Minimizing the underwriting risk relative to employees and their dependents who do not enroll in the health care program when first eligible by excluding benefits for pre-existing conditions (effective March 1, 1987).

Conducting, on a regular basis, compliance audits to help assure that groups are enrolling only those employees and dependents who are eligible in accordance with eligibility provisions of the group contract (effective Fall 1987).

Minimizing the underwriting risks associated with high risk group applicants by requiring the completion of health questionnaires and excluding benefits for pre-existing conditions (effective March 1, 1988).

Effective October 1, 1988, another measure will be implemented which also should have a favorable impact on claims expense. ALL ELIGIBLE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS WHO ENROLL IN YOUR GROUP ON OR AFTER OCTOBER 1, 1988, WILL BE REQUIRED TO COMPLETE AN ENROLLMENT FORM WHICH CONTAINS HEALTH QUESTIONS EVEN THOUGH THEY ARE ENROLLING WHEN FIRST ELIGIBLE. Their coverage will become effective on the first of the month following completion of the medical underwriting, but not before your group's eligibility period has been satisfied. Benefits will not be provided for pre-existing health conditions. (A small supply of this new form is enclosed for your use. You may, of course, reproduce it for future use, or call your enrollment specialist for additional copies as needed.)

Should your group's monthly enrollment average 10 or more during our annual review period, your renewal notification letter will advise you that new employees and dependents enrolling during the coming contract period will not be required to answer the health questions included on the enrollment form. Of course, the usual 10-month waiting period will continue to be applied to new enrollees.

Please attach this Letter of Amendment to your copy of the Group Contract.

Should you have any questions about this policy change, please contact the enrollment specialist for your group by calling the telephone number shown on your monthly billing. It is our pleasure to continue to be of service to you.

Very truly yours,

L. H. Sample, Jr.
Manager
Contract Administration

AUGUST 17, 1989

MR. ROGER FLANERTY
FLOOR COVERING RESOURCES
4212 HOWARD AVE
KENSINGTON MD 20895

RE: GROUP NUMBER A819
RATES EFFECTIVE: 11/01/89

DEAR MR. FLANERTY,

After careful review of your group's subscription rates, we find it necessary to raise your monthly premium effective 11/01/89. We are taking this step because of increases this year in the cost and utilization of health care services in the Washington metropolitan area. The adjustment is based in part on your group's claims experience as well as the collective experience of other local groups similar in size to yours. Your monthly subscription rates for the coming contract period are attached to this letter.

Because we value your business, let me point out that there are several steps your group can take to help offset the effects of this premium increase. Depending on the type of coverage you have now and what modifications you make in the near future, your group may realize significant savings. I'd be happy to work with you, if you like, to reevaluate your existing benefits plan to identify what changes, if any, might be in your group's best interests.

In general, however, the following measures will cushion the impact of this rate increase. They include: raising your group's annual deductible, reducing the number of hospital days that are available to your employees or changing the level of reimbursement under your group contract for doctor's bills and other professional medical services.

In addition, please consider two new products Blue Cross and Blue Shield of the National Capital Area (BCBSNCA) has developed during the past year to help our customers contain costs.

The first is called Dual Option. With this product, your employees have a choice of joining a traditional indemnity plan, or selecting HMO-type benefits through BCBSNCA's affiliate, CapitalCare Administrative Services, Inc. Both options -- traditional indemnity and HMO -- are priced the same. That way, your employees can choose the type of health benefits program that best suits their family or individual needs, instead of making a decision

based on price. Each option offers a comprehensive benefits package that includes hospital, maternity, well-baby and physician care, medical treatment in an emergency, outpatient diagnostic testing, laboratory services and x-rays. The two options differ in their out-of-pocket expenses and in the freedom of access your employees and their eligible dependents will have to doctors and hospitals in the Washington metropolitan area.

We also have another new product, built around our Preferred Provider network, that may save your group up to 15 percent. The Preferred Provider network is an arrangement between BCBSNCA and a group of 26 local hospitals and over 2,600 doctors and other medical specialists in the Washington metropolitan area. Because of our specially negotiated discounts with these providers, we can offer your group a less expensive alternative to the traditional indemnity plan you have now. Network subscribers may go to the doctors and hospitals of their choice, but they receive a financial incentive in the form of enhanced benefits and fewer out-of-pocket costs for using the Preferred Provider network.

Finally, to follow up on the Letter of Amendment we sent you in July of 1988, your group has been classified as medically underwritten for the contract period which coincides with this rate increase. This designation is based on the number of employees who were enrolled in your group at the time of our rate review. What this means is that any participant from your group whose coverage becomes effective during the new contract period will be required to fill out and file a medical history questionnaire with us before qualifying for covered services. As a result, these subscribers may be permanently excluded from receiving Blue Cross and Blue Shield benefits for conditions which existed before they enrolled.

I'd be happy to explain all these alternatives to you and compare rates so that you can decide which one is best for your group. Please call me at your earliest convenience.

Sincerely,

R. A. FREEMAN
Account Executive
(202) 479-8540

Blue Cross
and
Blue Shield
of the National Capital Area

550 12th Street, S.W.
Washington, D.C. 20065
202/479-8000 Telex 140985 Cable BLUE
Chartered by the Congress of the United States

September 27, 1989

Mr. Sal P. Ercolano, Sr.
Acting Chief Investigator
Life and Health
Department of Licensing and Regulation
Insurance Division
501 St. Paul Place
Baltimore, Maryland 21202-2272

Dear Mr. Ercolano:

This is in response to your letter of September 7, 1989 regarding rate increases for Floor Covering Resources. Ms. Karin Allen has addressed our group rating practice for small groups. With that in mind, I have provided a description of our rating practices and alternatives available for Floor Covering Resources.

Floor Covering Resources is part of our 2-49 Community Rated Pool. The base rates are established by using the aggregate claims expense of the entire pool.

During the past two years, we also differentiated our rate increases in this pool by classifying those groups as either low, average or high risk groups. This was done to more equitably distribute the rate increases so that those small groups which used the least health benefits received a lower increase than those groups which used more health services.

The determination of risk category was made by comparing the paid claims of the prior calendar year with the premium generated during the same period. To safeguard against penalizing a group account for large individual claims, any participant claims in excess of $2,500 were discounted prior to the comparison of claims to premiums. A group where claims to premiums ratio is greater than 71% is considered a high risk group.

Floor Covering Resources was classified as an average risk group on their November, 1988 rate renewal. On the subsequent November, 1989 renewal, the 1988 incurred claims were $19,840. Of those claims, $15,064 were discounted because they were greater than $2,500. The health premium for the period was $4,206, a 84% claims to premium ratio which is classified as high risk.

Floor Covering Resources does have alternatives available to lower their health care costs. The group can retain their current benefits with our PPO Overlay Option and still reduce their rates as shown in the following illustration:

Age	Current Rates	Rates With PPO Overlay Option
29 and under	$181.74	$156.22
45-49	$379.96	$324.68

As you may notice, by retaining their current benefits with the PPO Overlay, Floor Covering Resources can realize an immediate savings of 14.38% over their new rates. Another option that is available for them to consider is our Standard Hospitalization and Major Medical with a $500 deductible and a $2,000 stoploss. The rates for that program would be $144.42 and $299.12 for both the individuals covered.

We at Blue Cross and Blue Shield of the National Capital Area share Ms. Allen's concerns about the escalating health care costs. Our rating method does provide a more equitable distribution with lower rates to lower utilizers of health care services. Conversely, groups with older/higher utilizers of claims receive higher than average premium rates. One of our Representatives will be in touch with Ms. Allen to discuss the various options that are available to Floor Covering Resources.

Thank you for the opportunity to respond to Ms. Allen's concerns. If you have any further questions, you can reach me at (202) 479-8800.

Sincerely,

George A. Brown
Vice President and General Manager
Consumer Acccunts

re: Karin Allen
Group #A819

November 1988

GROUP NUMBER: A819

MONTHLY RATES

AGE RANGE	SELF-ONLY	FAMILY
29 AND UNDER	$ 96.22	$ 224.50
30 - 34	120.20	269.40
35 - 39	144.32	314.30
40 - 44	176.40	426.56
45 - 49	208.48	538.80
50 - 54	256.58	606.16
55 - 59	304.68	695.96
60 - 64	360.82	808.20
65 AND OVER	441.00	987.80

COMPLEMENTARY TO MEDICARE: $131.64

November 1, 1989

GROUP NUMBER: A8190000

MONTHLY RATES

AGE RANGE	SELF-ONLY	FAMILY
29 AND UNDER	$ 181.74	$ 429.12
30 - 34	224.22	507.84
35 - 39	266.70	586.56
40 - 44	323.34	703.38
45 - 49	379.96	980.20
50 - 54	464.90	1098.28
55 - 59	549.86	1255.74
60 - 64	648.96	1452.56
65 AND OVER	790.54	1767.46
COMPOSITE RATES	280.85	0.00

COMPLEMENTARY TO MEDICARE: $174.66

1991

GROUP NUMBER: A8190000

MONTHLY RATES

AGE RANGE	SELF-ONLY	FAMILY
29 AND UNDER	$ 173.84	$ 410.66
30 - 34	214.34	485.68
35 - 39	254.82	560.70
40 - 44	308.84	748.28
45 - 49	362.82	935.86
50 - 54	443.82	1048.42
55 - 59	524.80	1198.48
60 - 64	619.30	1386.06
65 AND OVER	754.30	1686.18
COMPOSITE RATES	308.83	0.00

COMPLEMENTARY TO MEDICARE: $141.74

Enrollment Information Form
with a Health Questionnaire

Blue Cross / Blue Shield

PLEASE PRINT ALL INFORMATION

IMPORTANT – Please be sure that all of these questions and the questions on the reverse side are answered. Failure to give complete information or to sign this application will necessitate our returning it to you, delaying your enrollment.

ENROLLMENT INFORMATION

Applicant's Last Name	First Name	Initial	Occupation	Social Security or Railroad Retirement No.

Mailing Address	State	Zip Code	Employer

SEX	MARITAL STATUS	DATE OF BIRTH (Month / Day / Year)	HEIGHT	WEIGHT	GROUP #	
☐ Male ☐ Female	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Legally Separated					Date Employed Full Time / Date Employed Part-Time

COVERAGE DESIRED

I WISH: (CHECK ONLY ONE BLOCK)

☐ SELF-ONLY COVERAGE

☐ COVERAGE COMPLEMENTARY TO MEDICARE (Self-only coverage)

☐ SELF & DEPENDENTS (Please list all family members to be covered within "Dependent Information Section")

☐ SPONSORED CHILD (Please indicate Parent's ID Number): _____

ADDING FAMILY MEMBER(S)

Change Coverage to: ☐ Family. Please list in the "Dependent Information Section" all family members to be added.

If adding a spouse give date of marriage: Month / Day / Year

If currently being carried with employed or if you have abandoned legal guardian, give date of adoption or court decree: Month / Day / Year

DEPENDENT INFORMATION (Complete only if you have selected Self & Dependents coverage above or are adding family members)

LIST IN ORDER OF AGE OLDEST FIRST. (If dependent's last name is different from the applicant's please indicate. If you have additional dependents please list them on a separate sheet of paper and attach it to this form)

	First Name	Initial	Date of Birth (Month / Day / Year)	Relationship to Applicant	Height	Weight
2				☐ Husband ☐ Wife		
3				☐ Son ☐ Daughter		
4				☐ Son ☐ Daughter		
5				☐ Son ☐ Daughter		
6				☐ Son ☐ Daughter		

OTHER INSURANCE INFORMATION

☐ Check the block if you (or any dependent listed above) are now or have recently been enrolled in health care coverage through a Blue Cross and/or Blue Shield Plan, a Health Maintenance Organization (HMO) or other insurance carrier? If you or your dependents have been, please provide the following information:

1. Policy Holder Name: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female
   SSN: _____ (of Policy Holder)
2. Insurance Company/HMO Name: _____
   Address of Insurance Company/HMO: _____
3. Policy Covers: ☐ Policy Holder ☐ Two Person (name of dependent _____) ☐ All family members listed above
4. Effective Date of Policy: _____ (MO. DAY. YEAR) 5. Cancellation Date of Policy: _____ (MO. DAY YEAR)
6. Coverage is for: Medical ☐ Yes ☐ No Vision Care ☐ Yes ☐ No Dental ☐ Yes ☐ No
   Prescription Drugs ☐ Yes ☐ No ☐ Other (Specify) _____
7. Policy Number: _____
   Name of Group/Employer: _____
8. For parents living apart, give the name and relationship of the person responsible for providing medical coverage for dependent children.
   Name: _____ Relationship to Applicant: _____
9. ☐ Check this block if you (or any other person(s) listed on this application) are eligible for or receiving benefits under Medicare. If you have checked the block, please give:
   Name: _____ Medicare Claim No. _____ Eligible for: ☐ Part A ☐ Part B
   Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled
   Name: _____ Medicare Claim No. _____ Eligible for ☐ Part A ☐ Part B
   Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled
10. Daytime telephone number: _____

THIS AREA IS FOR OFFICE USE ONLY

Identification Number:	Service Code:
Group Number:	Effective Date of Coverage:

Health Questionnaire

CHECK EACH ITEM YES OR NO (If confidentiality is desired, please make arrangements with your Group Administrator.)

SECTION A – To the best of your knowledge and belief has any person named in this application had, within the last ten years, or does such person now have, any of the following?

YES	NO	
( )	( )	(a) Cancer, tumor or other growth
( )	( )	(b) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC)
( )	( )	(c) Kidney stones, kidney or bladder trouble, urinary frequency or burning
( )	( )	(d) Goiter, thyroid trouble, diabetes
( )	( )	(e) Seizure disorder, nervous or mental disorder, alcoholism, liver ailment
( )	( )	(f) Addiction to drugs for which such person has been treated or hospitalized
( )	( )	(g) Gall bladder trouble, hernia, stomach or intestinal trouble, ulcers, hemorrhoids
( )		(h) Cataract or other eye condition
( )	( )	(i) Tuberculosis or lung condition, asthma or bronchitis
( )	( )	(j) Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, gout
( )	( )	(k) Heart trouble, abnormal blood pressure, anemia, rheumatic fever
( )	( )	(l) (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, sexually transmitted diseases
( )	( )	(m) (Female) Is currently pregnant, expected date of delivery _____
( )	( )	(n) (Male) Prostate trouble, sexually transmitted diseases

SECTION B – In addition to the conditions listed in SECTION A above, to the best of your knowledge and belief, within the last five years has any person named in this application.

YES	NO	
( )	( )	(a) Consulted a physician or other provider for medical or surgical treatment or advice for any condition not listed in SECTION A?
( )	( )	(b) Had any departure from good health not previously mentioned in SECTION A or question (a) of this section?
( )	( )	(c) Had a physical examination?

SECTION C – If you have checked "YES" to any part of SECTION A or SECTION B, please provide complete information regarding diagnosis or condition, treatment including all medications, hospitalizations, surgery, and diagnostic testing results, and dates. (If more space is needed, attach a separate sheet of paper.)

Patient's First Name	Diagnosis or Condition	Question Dates From	To	Explain treatment including all medications, hospitalizations, surgery and diagnostic test results	Recovery (Check only one box)	
					( ) Full	( ) Partial
					( ) Full	( ) Partial
					( ) Full	( ) Partial
					( ) Full	( ) Partial
					( ) Full	( ) Partial
					( ) Full	( ) Partial

Please Read Carefully - This Section Must Be Dated And Signed

IT IS UNDERSTOOD AND AGREED THAT:

(a) The statements and answers made herein are complete and correct to the best of my knowledge and belief, and are made to cause the issuance of, and to become a part of, the coverage applied for.

(b) The coverage will become effective the first of the month following approval of this application by Blue Cross and Blue Shield of the National Capital Area (hereafter "Corporation").

(c) Should any statements or answers contained in this application be untrue (if such statements are fraudulent or material to the acceptance of this application), then the coverage may be cancelled by the Corporation, and their obligation shall consist only of the return of any subscription charges actually paid, less the amount of any benefits paid under the coverage.

(d) The Subscriber shall repay to the Corporation the amount of any payment made in error to the Subscriber on behalf of the Subscriber or any covered family member as the result of a claim.

(e) Any physician, nurse, hospital or other provider (hereafter "Provider") having treated or attended me or any of my family members listed on this application, and having possession of any records or information with respect thereto, is authorized and directed to provide such information or records to the Corporation upon request for the purpose of evaluation of this application. This authorization is valid for 30 months.

(f) If this application is approved by the Corporation, I authorize any Provider to forward to the Corporation information concerning medical services or supplies provided to me or to any of my family members listed on this application for the purpose of review, investigation or payment of a claim. This authorization is valid for the duration of coverage.

(g) A copy of this application is available to the Subscriber (or a person authorized to act on his behalf) upon request.

Date X _____ Signature of Applicant X _____

(If applying for sponsored coverage, signature of Parent X _____)

Gray Panthers of Montgomery County
P. O. Box 164
Kensington, MD 20895
(301) 622-3213

Senator Mikulski Hearing on
Health Care 4/23/92

For Information Contact: Abraham Bloom (301) 942-4254

My name is Abraham Bloom and I am presenting this statement for the Gray Panthers of Maryland. We are committed to the need for a National Health Plan based on a Single Payer System.

Everyone is aware that our present Health Care non-System is in crisis. It shows itself in many ways.

For the Elderly Medicare has failed. It does not cover dental care, eye care, prescription drugs, or long term care, all of whose costs have been rising at two to three times the rate of inflation. As a result seniors today pay 18% of their income for health care compared to 15% in 1965 before Medicare went into effect.

For the Poor Medicaid has failed . It depends on state money for half its budget. The states being in a financial bind have failed to fund Medicaid adequately. In Maryland, income eligibility is set at 40% of the poverty level. Payments to providers has been cut. Medicaid has become a poor quality program.

For All Others There is a lack of access and an unwarranted escalation of costs.

One person in four is uninsured, 1/3 are children. Women go without pre-natal care and children without needed inoculations.

We spend more than any other country in the world, yet other countries insure everyone, and get better health results. 22 countries have lower infant mortality and 15 have higher life expectancies.

Not only are our costs too high, but they are continuing to escalate and are estimated to rise from 12 % of (GNP) today to 17.5% in the year 2000.

What is to be done ? We recommend support for the Single Payer Plan in Senate Bill S. 2320 introduced by Sen. Wellstone and co-sponsored by Sen. Simon and Sen. Metzenbaum.

It provides a comprehensive package of benefits, including hospital and physician care, long term care, prescription drugs, preventive care and mental health benefits.

Everyone would be covered and would only have to present their health card to the provider of their choice, to receive treatment. The federal government would be the single payer, but the program would be administered by the states.

The plan would contain costs. The General Accounting Office (GAO) has estimated that the adoption of a single payer system in the U.S. would save $67 Billion in administrative costs alone, more than enough to pay for coverage of all the uninsured.

In addition to these administrative savings, because the federal government is the sole payer, it is in a strong position to contain costs thru negotiated prices on prescription drugs, negotiated physician fees, global budgets for hospitals and control of capital expenditures.

This plan overall will not cost more money. There will be new taxes, but less private spending on insurance and out of pocket costs. The net cost for most people will be less. For instance, a family of four with income of $39,200 will save $1600.

We must respond to some of the horror stories that have been spread by the AMA and the Insurance Companies about the Canadian Single Payer System. They say that people must put up with long waiting lines to get necessary treatment. These stories are untrue.

Reports from Canadian doctors are that in fact Canadians are availing themselves more of services than people here in the U.S. There is more preventive care, which avoids later more serious and expensive illnesses.

We have the advantage in this country that our health care expenditures are at a higher level, 12% of GNP vs 8.6% of GNP for Canada and we have much high tech equipment already in place. Since there are no plans to cut these expenditures or facilities we could in this country supply even better services not less.

Polls show that Canadians are more satisfied with their health care system than citizens in any other country. Similar polls show that U.S. citizens are least satisfied. Here in the U.S. we have 37 million uninsured who would just love to get on the Canadian waiting lines.

Compared to the Single Payer Plan, we find that the Play or Pay proposal introduced by Sen. Mitchell as S. 1227, would set up a very inferior system.

S. 1227 mandates that employers provide Health Benefits for their workers or pay a tax into a public fund that would be used to provide insurance for all those not covered on their jobs.

The major defect of this plan is its heavy dependence on private insurance with its high administrative costs, high marketing costs, and high profit margins. Their benefit payout averages 60c on the dollar, compared to public systems like Social Security and Medicare which have benefit payouts of 98c on the dollar.

Insurance companies are difficult to control. Because they are exempt from anti-trust laws and are regulated on a state level with 50 different sets of state regulations. (S.1227 has tried to prevent some of the worst abuses such as the refusal of coverage for people with previous health conditions).

There are other problems with S.1227:

Many small businesses cannot afford the mandated coverage or the added tax imposed. For them, it can lead to business failures.

There will be an administrative nightmare to keep track of workers who change jobs, and have to change insurers and providers or those who become unemployed and must switch from the private to the public plan.

For the elderly, who are covered by Medicare, S. 1227 will be of no help. They continue on Medicare with all its deficiencies.

Real cost containment will be sacrificed, because the strength of a strong federal government negotiator will be lost.

The deficiencies of Play or Pay compared to the Single Payer Plan are obvious. The insurance companies should not be allowed to hold the American people hostage to an inferior program.

While we can understand why Sen Mikulski may want to support the Democratic Party leadership by support of S.1227, we believe that she should recognize the superiority of S.2320 and also become a co-sponsor of that bill. We urge her to do so.

Finally we should briefly discuss an aspect of people's health that does not get enough attention. While a good health care system is essential, it is not enough. Improvement in people's standard of living is another essential, particularly for low income persons. Good health depends strongly on good nutrition, good housing, good sanitation and good education.

We must also put much more emphasis on prevention. For instance, Maryland has the unfortunate distinction of having the highest cancer rate of any of the 50 states. To rectify this we must develop effective programs to reduce smoking, alcohol consumption and to clean up our environment.

Thank you.

Jonathan Lawniczak, Senior Health Policy Analyst
National Council of Senior Citizens

Introduction

Good morning, Madam Chairman, Members of the Committee. It is a pleasure to be here today. My name is Jonathan Lawniczak. I am the Senior Health Policy Analyst for the National Council of Senior Citizens (NCSC). NCSC represents over five million older Americans nationwide through our 5,000 affiliated clubs and State Councils. The National Council was founded in 1961 to lead the fight for Medicare. After its enactment--an event we considered the first step in the creation of an American National Health Care system--the Council turned to other advocacy issues. These include Social Security and retirement income, housing, civil rights, transportation and employment programs for older citizens. But today we see these issues being overwhelmed by the economic and social pressures generated by the need to reform our national health system and to provide for the inclusion of long-term care in any national health plan.

Health System in Crisis

Every day a new story about the deterioration of our health care system appears in the press. The stories range from the effects on individuals and impacts on business, to our global competitiveness and the economic stability of the nation.

On October 9, 1991, the Washington Post reported that the Pentagon plans to consolidate its health care system in order to use defense dollars more efficiently.

On October 5, 1991, an article in the Los Angeles Times discussed the situation of employers in Los Angeles who pay almost twice as much for health insurance than employers do in other parts of the nation. Employers, so the report states, could save hundreds of thousands of dollars without reducing benefits by relocating. Of course, for workers, the choices are devastating: lose your job or move away from your family and friends.

October 6, 1991, the Washington Post ran an extensive article on the costs of home care and how consumers are often taken advantage of due to the lack of government regulation.

The Christian Science Monitor reported on October 4, 1991 that by the year 2000, doctors' income will have doubled to an average of $458,000 per year.

On June 28, 1991, the Wall Street Journal reported the results of a poll on important issues facing the nation. The poll identified health costs and coverage as the most important issues along with the state of the economy. The poll showed an activist mood on the part of the public--51 percent said the federal government is held responsible to solve the health care issues. Sixty-nine percent would be willing to pay more taxes for a program "guaranteeing everyone the best health care available." Sixty-nine percent said they could support a health system similar to Canada's.

Retirees Affected

Seniors, who were supposed to be insulated from health care costs through the Medicare program, are feeling the squeeze on a par with the rest of the population. In 1981, the Medicare Part A hospital deductible was $204. Today it is $628--an increase of over 300 percent. Over the same period, Social Security benefits have increased only 34 percent and few private pensions have any cost-of-living adjustment provisions at all. Ten years ago, the Medicare Skilled Nursing Facility co-payment was $22.50 in 1981. This has increased by over 350 percent--to $78.50. The Part B premium was $11 a month in 1981. Now it is $29.90--an increase of 270 percent. In 1995, the premium will reach $46.10--an increase from 1981 of 420 percent. The only Medicare out-of-pocket expense for the elderly and disabled which has remained relatively stable is the Part B deductible. In 1981, it was $60. Today it is $100--an increase of 67 percent. In 1981 the elderly spent 12.7 percent of their income on health care. In 1991, this figure is approaching 20 percent--more than they spent on health care before

the passage of Medicare. Cost increases in Medigap policies show the same out-of-control patterns.

And, I should make the point, Madam Chairman, that the rise in Medicare costs has been less than in some other sectors of the health care system.

Our members have consistently fought the battle for a national health care system. Our organization has always considered the passage of national health care to be our number one long-range priority, and this in the face of our evaluation that seniors actually had the least to gain from passage of such an act. However, in today's climate, we find that seniors have much to lose through Congressional inaction, and will benefit greatly from the prompt passage of a comprehensive national health insurance bill.

Many retirees depend on benefits earned while working to provide supplemental insurance to plug the gaps which Medicare leaves open. According to the Employee Benefit Research Institute (EBRI), over 50 percent of retirees receive their Medigap coverage through their former employers. These benefits are increasingly at risk. A recent EBRI survey indicated that five percent of employers with retiree plans intend to drop coverage entirely, while over ten percent expect to reduce benefits. Over 30 percent plan on increasing retiree deductible and co-insurance. These numbers will only increase as the new accounting standards issued by the Financial Accounting Standards Board (FASB) go into full effect.

Under FASB rules, employers, for the first time, will have to list as a liability any unfunded promises to provide health insurance programs for retirees. Not only will businesses have to include their current retirees, but they will also have to include the over 11 million current workers who are promised some type of health benefit after retirement. The possible implications of this action for the maintenance of retiree health benefits are staggering.

Equally alarming is the disastrous effect that bankruptcies are having on retiree health benefits. When Eastern Airlines went

out of business, they took their retiree health benefits with them. In large part, the Pittston mine strike was about retiree health benefits and broken promises. When LTV decided they could not stay in business, the first thing they wanted to do under bankruptcy reorganization was to eliminate their obligations to the men and women who spent their working lives building the company. Congress helped ameliorate this problem somewhat when it passed a law stating that retiree health benefits did not automatically disappear when a company filed for Chapter 11 protection. While this was a helpful first step, it does not go to the root of the problem.

Even with the protection provided by the Medicare program and with sound supplemental policies, most elderly persons have critical unmet health care needs. Sixty percent of the elderly pay for prescription drugs totally out of pocket. The one area where the majority of consumers are responsible for all costs is in prescription drugs. Yet, according to the Senate Special Committee on Aging, drug prices in America are higher than in any other country in the world. From 1980 to 1990, while general inflation was 58 percent, inflation in the price of drugs was 152 percent. Obviously, controls are needed to contain costs in this area. We think the most feasible method of containing drug costs will be in the context of a universal national health program which covers pharmaceuticals.

Long-term Care

Community-based and institutional long-term care is a critical need of older persons as well as of impaired citizens of all ages and their family caregivers. The Pepper Commission estimated that at least one-third of all those who could use long-term care are under the age of 65. But families are affected in other ways: fifty-two percent of families who now have elderly parents have been caring for one or both of them from between three to eight years. Fifty-six percent spend more than 12 hours a week cooking

meals, running errands, helping with checkbooks, and giving medicines. Twenty-six percent of the caregivers are part of the "sandwich generation," caring for both their children and their parent simultaneously. The average age of caregivers is 50. NCSC has always felt that long-term care must be an integral part of any comprehensive reform effort.

NCSC Position

Madam Chairman, the National Council has a defined position on national health care which has been honed over the years. Rather than develop a specific legislative proposal, we have constructed a set of ten principles by which we endeavor to evaluate health reform legislation. These principles have undergone change. In January of 1990, at our Constitutional Convention in Chicago, our delegates deleted a principle calling for a role for the insurance industry. Last May, our General Board added a principle stating that any legislation supported by the National Council must incorporate clear steps moving toward a single-payer system including a uniform national payment mechanism. We attach these principles here in the hope that you and your colleagues will use them in crafting final legislative proposals for comprehensive reform legislation.

NATIONAL HEALTH CARE PRINCIPLES

1) Universal Access

Under the program, every American will be covered, regardless of ability to pay. Basic health protection must be considered a right and the program must clearly establish this principle.

2) Comprehensive Benefits Including Long-Term Care

In addition to protection for hospitalization and physician services, the program must cover all medically necessary health and preventive services, long-term institutional and home health care, and other essential health services.

3) Financing

Any system of financing a new national health care program must be broad-based and progressive, based upon our nation's traditional approach to financing social insurance programs.

4) Cost Sharing

Cost-sharing requirements on beneficiaries must not create economic barriers to receiving adequate health care. Deductibles and co-payments penalize the sick and therefore should not be relied upon as sources of financial support for the program. All physicians would be required to accept assignment and would not be allowed to pass along additional fees to beneficiaries.

5) Quality Assurance

Standards would be established to govern patient care in all medical settings. Independent oversight of the medical profession and peer-review organizations would monitor the quality of all medical care. Physicians, nurses and other health care professionals who have demonstrated a commitment to providing the highest quality care should be recognized and rewarded.

6) Cost Containment

A system of budgeting for all health care services would be established and adhered to in determining payment policies to service providers. Prospective hospital budgeting and a national physician fee schedule coupled with expenditure targets and negotiated on an annual basis will act to control health care costs.

7) Health Planning

Resources for capital expenditures on new construction and rehabilitation of existing facilities would be allocated on the basis of local, state and regional needs for additional health care services. This will ensure that the health care needs of all our citizens will be considered in determining spending patterns for the use of new technologies and services.

8) Patients' Rights

Patients must be treated in a timely manner and with compassion and decency and a patient-grievance procedure must be established. The burden of seeking reimbursement for services rendered should fall on the health provider and not the patient.

9) Program Administration

The national health program will be administered in such a way as to assure a strong role for the Federal government and the states. In addition, health care consumers must have the right to participate in the administrative and policy-making decisions at all levels of government.

10) Payment Mechanism

In working toward a single-payer system, the National Council should support legislation incorporating progressive steps creating a uniform national payment mechanism financed through social insurance principles.

Madam Chairman, we have utilized these principles in evaluating legislation pending before this Committee and the House. Many bills meet at least some of these principles, such as comprehensive benefits, strong cost-containment and feasible and efficient administration. Our examination of all the pending bills leads us to a finding that H.R. 1300 and S. 2320, introduced by Congressman Marty Russo and Senator Paul Wellstone, come closest, at this time, to meeting the intent of our principles and promises a sound framework on which to provide comprehensive and efficient services under conditions that would enhance quality of care for all citizens. We believe that this bill will provide an effective control of escalating health costs. It is not perfect, but it goes a long way toward meeting our goals.

We suggest that this bill deserves the support of citizens young and old and the serious consideration of the Congressional leadership and all Members.

Madam Chairman, it is our experience that the most sound public programs enacted are those which are <u>inclusive</u> by intent and design. The most popularly supported Federal and local programs are those which meet, at a basic level, the common needs of citizens. These programs incorporate equitable methods of universal contributions in exchange for benefits or services received by all within a range of reasonable definitions of qualification. Medicare and Social Security are good examples. So is community-level fire protection. So is federal deposit insurance and public health requirements which include mandatory inoculations of children. Such programs respond to the sense of community, equity and practicality.

Health care, we believe, is one of the few issues which merits consideration as a basic human need and right. Instinctively, the American people have come to a recognition (and we believe that it is growing every day at a rapid rate) that all citizens must have access to comprehensive quality health care, not on the basis of income, employment status, age, sex, race, geography or education,

but rather on the basis of their membership in the national community.

The single-payer model provides a clear approach to such inclusiveness in the provision of care to all while having the greatest potential for holding the political support of working people and the middle class. Madam Chairman, at bottom, we are talking about the viability of this legislation in terms of political support and a reasonable promise of efficiency and cost containment. Our judgment is that the model provided by H.R. 1300/S. 2320 does best inspire that support and the confidence that costs of care can be held to a reasonable part of personal and national budgets.

There remain concerns about the possible adoption of H.R. 1300/S. 2320. Questions arise, such as, "Can the government run such a large program? Can we see the doctor of our choice? Will we have to wait in line for necessary surgery or services? Won't we have to ration care in order to cover everyone?" These are serious concerns and deserve our serious attention.

There is abundant evidence that our government can do the job. Governments in every industrialized national of the world provide health care for their citizens. The U.S. government finances and manages health care for 33 million older and disabled Americans through the Medicare program while retaining a private provider infrastructure for the delivery of care. Our government provides health care for our veterans, for military personnel and their dependents, for civilian employees, for low-income citizens and for other groups. The U.S. government runs the Public Health Service and the National Institutes of Health. The public sector of this country already pays 42 percent of all health care expenditures. Again, the performance is not perfect, but it provides an excellent base for the creation of a publicly accountable system of health services.

Under H.R. 1300/S. 2320, citizens would be able to see the physician or provider of his or her choice. While this freedom of choice is recognized as being one of the most important aspects of

our health delivery system, Americans are really able to see a physician only if that doctor accepts the insurance held by the patient or if the patient is willing to pay the entire bill out of pocket. As more and more people join managed-care organizations, they will find their choices even more restricted. Other proposed health care legislation would continue the restrictions already in place or would impose more restrictions upon consumers. A single-payer system, such as administered in Canada, would allow consumers a wide range of freedom of choice of providers. H.R. 1300/S. 2320 mirrors this model of choice.

Would we support a national health system in which people had to wait in line for necessary surgery or have to ration care? Of course not. The experts state that we currently have enough excess capacity to provide universal coverage, with long-term care, for a decade without lines and without rationing. No one is proposing a ratcheting back of our health system. We only want to get costs under control. Only when we fill those 300,000 hospital beds which go empty every day should we add more beds.

In short, we should manage our health care services on the basis of rational choices from among existing or feasible options. Our current system responds largely to market forces, bureaucratic private restrictions and to uncoordinated public programs. This has led to our current crisis and a future bleak with the nightmare of further restraints on services even as we bleed our economy dry with the unconstrained costs of a system out of control.

Conclusion

The American people want a universal health care system and we believe that polls and public calls for reform show that the public is far ahead of those of us who work inside the Washington beltway. They want a system where an inner-city youth will receive the same care as the President of the United States. H.R. 1300/S. 2320, among other bills, gives us confidence in the probability of this level of care as the norm.

A single-payer approach makes it possible to expand access and provide long-term care for the nation's chronically ill population while holding down costs. H.R. 1300/S. 2320 provides comprehensive community- and home-based care, in addition to institutional long-term care. As a practical matter, only the single-payer approach allows us to eliminate cost-sharing burdens which inhibit access to care and increases administrative costs. H.R. 1300/S. 2320 specifically bars cost sharing.

The administrative savings of adopting the H.R. 1300/S. 2320 model are incontestable. The General Accounting Office reports that the nation could save $67 billion a year by adopting a Canadian-style health care system. Other studies have suggested even greater savings. Such savings could be used to create new services and to continue the U.S. lead in research and innovation.

The adoption of H.R. 1300/S. 2320, or a similar model, would not put the insurance industry out of business. Life, fire and auto insurance policies would continue to flourish with the U.S. economy.

We realize that some are skeptical about the willingness of the American people to adapt to this change. You already have listened to the doubts of doctors, the hospital administrators, to the insurance industry. Now, we urge you to return to your districts. Hold town meetings. Ask your voters. Ask your seniors. Ask your blue-collar workers. Ask your while-collar workers and your middle-class professionals and small business persons.

They are prepared to talk to you about what they want. They want a national health care program that provides every American, young and old, with comprehensive, quality health care. They want long-term care included. They want help in keeping costs down and they want to make sure that the system is financed fairly. They want the rights of patients and families protected including the right to choose their own doctors. They want healing and not red tape and paperwork.

That is also what the National Council wants and what H.R. 1300/S. 2320 gives promise of making possible.

Madam Chairman, we need your support and your leadership. We want your guarantee that H.R. 1300/S. 2320 will have a full and fair hearing before this body, and the Congress as a whole.

Thank you.

TESTIMONY ON HEALTH CARE REFORM

Offered at a Hearing Held by United States Senator Barbara A. Mikulski at Dundalk Community College on Thursday, April 23, 1992

I am Frederick F. Otto, AARP Maryland State Legislative Committee Chairman speaking on behalf of approximately 600,000 American Association of Retired Persons in Maryland. AARP members are deeply concerned about the skyrocketing cost of health care and about the fact that some 34 million Americans, 570 thousand Marylanders, have no health insurance and another 20 million are underinsured,340 thousand Marylanders. They are also concerned about the lack of a national long-term care program for the growing number of Americans of all ages who need such care. (A report in the "New England Journal of Medicine" estimated that 43 per cent of all Americans reaching age 65 will spend some time in a nursing home and that one out of five of these will spend five years or longer in such a facility at a cost of at least $25,000 per year.)

AARP believes that all Americans have a right to affordable, quality acute and long-term care as they need it throughout their lives. We are convinced that the United States has the resources to ensure access to acute and long-term health care for all and to control health care costs without compromising quality of care.

Any program that will provide all Americans with affordable acute and long-term health care will cost money and will require changes in the way health care is delivered and paid for in this country. But it is important to understand that the cost of not reforming our health care system will be even greater. If we do nothing, the cost of health care will continue to rise faster than the overall inflation rate and will consume a greater and greater share of our national resources. Additionally, the number of individuals who are uninsured or underinsured or who find health insurance unaffordable is likely to grow. Business will likely continue to reduce the coverage they provide for workers and retirees and continued attempts to solve our health care problems with piecemeal or "band-aid" solutions will only result in greater fragmentation of our health care system, more cost-shifting and higher administrative costs.

For these reasons, and for philosophical, political, economic and pragmatic positions that cannot be developed here because of time limitations, AARP is working to develop a comprehensive national health care plan called Health Care America that controls costs and provides high quality coverage to everyone, including those who need long-term care. The goals of AARP's draft proposal then are: (1) to control costs; (2) to assure access to care for everyone; (3) to provide comprehensive benefits including long-term care; and (4) to finance the system in a fair manner. The proposal is a draft that will be taken to the AARP membership during 1992 for debate, discussion, suggestions and modifications.

The cornerstone of Health Care America is the MEDICARD, a single health insurance access care for everyone. With this card, everyone, regardless of age, income or employment status, gains access to an improved and expanded Medicare program, or to equivalent or better coverage provided through an employer. Either way, there will be no more denials of coverage for "pre-existing conditions," no more people falling through the cracks, and no more overlapping plans and programs generating wasteful paperwork.

The card assures access to the full range of preventive, acute care, prescription drug, and long-term care benefits. There is no cost-sharing for preventive services, hospice, or hospital care, and only 10% coinsurance for most other services. For most individuals it will no longer be necessary to purchase supplemental insurance. Strict cost controls, malpractice reforms, and elimination of waste and duplication keep the program affordable.

The need for health care reform has become so great that it overrides what some may view as an organizational self-interest. Although AARP derives considerable revenue from providing health insurance to members, the Association will gladly forego every penny of it in exchange for a national system that provides universal access to quality care, real cost containment, and a way to pay for it that is broad-based and fair.

HEALTH CARE AMERICA has the following important advantages:

- It's easy to use and understand. Every person gets a health insurance access care--MEDICARD--to present to the health care provider, and receives one clear periodic accounting.
- It's far more efficient than our current system. Streamlined administration and electronic billing reduce wasteful administrative overhead.
- It controls costs, using national and state budget targets for spending. It also establishes standard rates for providers, places strict limits on prescription drug prices, prohibits balance billing, and reforms medical malpractice insurance to reduce unnecessary procedures.
- It provides for comprehensive benefit coverage for all age groups. Everyone automatically qualifies, regardless of employment status or income.
- It preserves the individual's freedom to choose health care providers, just like present-day Medicare.
- It places new emphasis on preventive care, to catch small problems before they become expensive tragedies.
- It provides all children with screening and treatment services to meet their dental, vision and hearing needs.
- It protects the already sick. No one can be excluded on the basis of an existing condition.
- It includes what most people don't have--long-term care coverage in the home, the community and nursing homes; prescription drugs; and affordable limits on total out-of-pocket expenses each year.
- It strengthens vital health research and quality assurance programs, so that our health care will continue to improve.
- It stigmatizes no one on the basis of income. Protections are available for the poor and low-income, without the drawbacks attached to the welfare-based Medicaid program. Medicaid is abolished.
- It leaves employers free to provide the same, or even more generous coverage, for things like eyeglasses or dental work, through benefit plans that meet the same strict standards for coverage and cost containment.

PAYING FOR THE PLAN. Most people believe that we are already spending enough to pay for all the health care we need--over $800 billion in 1992. This plan reduces administrative waste, but those savings are more than offset by the cost of greater benefits and services for all. Unfortunately, there is no free lunch--improvements in coverage and the reduction in out-of-pocket costs must be balanced by some increased tax revenues even as the total costs of health care are held down.

Health Care America will lower out-of-pocket costs for most people. The real impact of the plan, however, is that it gives the American people, for the first time, a means to limit the year-to-year increases in the cost of health care. It combines broader protection with effective controls on spending to provide real economic and health care security--now and into the future. In order to make this possible, however, new taxes are necessary. AARP has identified several sources of funding that are adequate to pay for the plan.

"Sin" taxes on alcohol and tobacco would be doubled, reflecting the health costs associated with their use. Corporations would pay a 5% surtax on their existing corporate income tax, reflecting the substantial savings that the plan offers many of them in lower health costs. Estate tax rates would be brought back to the pre-1981 levels in order to help finance the long-term care protections.

The new Medicare premium--$500 month for an individual in 1993--would not exceed 20% of the cost of the improved and expanded Medicare program. Monthly premiums would be set according to family size. In effect, everyone enrolled in Medicare, except those too poor to pay, would contribute monthly payments just as current Medicare beneficiaries do each month. Employers would pay an 8% payroll tax. This tax would be waived for employers who provide equivalent or better coverage privately to their employees and dependents. Employees covered under an employment plan would pay no more than 20% of the private plan premiums. Special provisions would protect new and low-wage businesses. The balance of the necessary funding would come from one of the following two revenue sources: (1) a special income tax of 3% that would apply to all income above $15,000 a year for individuals or $20,000 a year for families; or (2) a new 5% tax on consumption, called a Value Added Tax, that would apply to all goods and services, except food, housing, and medical care. (The tax would be refunded to low income persons.) Other tax adjustments would offset the regressive impact of a consumption tax.

This plan presented in summary form here has been developed in order to share with AARP members and the public a proposal that is built upon the principles for health care reform already adopted by AARP's Board of Directors. It is offered for discussion, debate, suggestions, and modifications.

The Association knows that any comprehensive health care reform plan will be controversial. We do not think controversy can be avoided if we are to fix the serious problems that our health care system faces. Debate is the essence of a democratic society. We hope this plan will move the health care reform debate close to resolution.

The following two charts reflect significant elements relating to Cost Sharing and Long-Term Care:

Deductible Single/Family	$200/$400
Annual Out-of-Pocket Limit Single/Family	$1500/$3000
Hospital Services, Inpatient	0% coinsurance
Physician & Surgical Outpatient Services	10% coinsurance
Home Health Care	10% coinsurance
Post-Acute Nursing Facility	10% coinsurance
X-Ray and Laboratory	10% coinsurance
Mental Health: • Inpatient • Outpatient	 0% coinsurance 10% coinsurance
Preventive Care (Mammography; pap smears; colorectal; prostate cancer screening; dental, vision and hearing screening)	0% coinsurance
Prenatal and Well-baby Care	0% coinsurance
Prescription Drugs	10% coinsurance

LONG-TERM CARE

Coverage	Individuals of all ages with serious disabilities or impairments.
Benefits	Home and community-based services including respite and adult day care. Nursing Home care.
Cost Sharing	
Deductible	None
Coinsurance	20% for home & community-based services. Maximum of 35% (room & board) for nursing home care, with financial protection for poor, low, and moderate income individuals.
Financial Protection	Income-related caps on coinsurance. No asset test.
Administration	National public program administered as part of Medicare. States contract with care management agencies which determine individuals' need for services.
Cost containment	Within an overall budget target, rates are set for nursing homes and home & community-based services are competitively bid.
Quality	Strengthened and independant quality assurance agencies. Focused on patient well-being.

CARL J. SARDEGNA
CHAIRMAN & CEO

BLUE CROSS AND BLUE SHIELD OF
MARYLAND, INC.

Good Morning. I would like to thank Senator Mikulski for convening this hearing today to discuss this very important topic - health care reform.

Problems with the health care system have been discussed for many years. However, the time has come when action, and not just words, is necessary.

Virtually everyone is unhappy with at least some aspect of the way our health care system works. Access and cost have been identified as the two major issues of concern.

The problem with addressing an issue as significant as health care is that when the need becomes so great to change the current system, there is sometimes an urge to seek a "silver bullet" to solve all of the problems. The system is so complex, simple solutions and slogans, such as "single payor" or "play or pay," will not work. I am reminded of H.L. Mencken's words: "There's always an easy solution to every human problem -- neat, plausible and wrong."

The reasons for change are clear:

- Spending levels on health care are far too high - between 12 and 13% of the gross national product and climbing;
- Approximately 34 million Americans and 570,000 Marylanders are uninsured;
- Health care costs are rising at more than two times the general inflation rate;

- Citizens who lose their jobs have additional fears about losing their health care coverage;

- Growing employee benefit expenses reduce business competitiveness;

- Piecemeal approaches have not resulted in affordable health care for all; and

- Administrative complexity and hassles are an increasing burden on the entire system.

Several proposals to address comprehensive reform to our nation's health care system have been proposed. When we distill them, three basic models stand out.

These are single payor, play or pay and consumer choice, which involves the use of tax credits/vouchers.

I contend that neither the single payor model, nor the play or pay model should be the models of choice for health care reform in the U.S. The result of the experience of other countries which have adopted the single payor system is a system which attempts to hold costs down through some form of rationing of health care. The single payor model discourages the competitiveness to develop new technologies.

The play or pay approach does not provide universal coverage. Under this approach, one-third of the population is left uncovered, including the unemployed and many part-time workers.

Both of these approaches would require a substantial increase in new funds at a time when the country is staggering under the weight of our deficit.

I am pleased to express support for a Consumer Choice approach, one version of which is being actively considered in Maryland as a statewide demonstration. I believe it can work in Maryland and I believe it offers a model for the nation, because unlike the other approaches, it achieves four critical health care reform goals. It:

- Provides universal and continuous access to quality health care benefits regardless of health, job or insurer;
- Moderates the increase in health care costs through the close management of health care and administrative costs and, critically important, through the involvement of consumers as prudent buyers and users of health care services;
- Achieves budget neutrality by using dollars which are already in the system; and
- Preserves what's good about the current system, particularly the right to choose the health care coverage that suits individual needs.

Under the Consumer Choice approach, each individual has access to a standard health care insurance package and can add more benefits if they desire. As a purchaser of health care insurance, each individual then becomes a stakeholder in the health care system.

One of the key reasons why health care costs are consistently higher than the Consumer Price Index is that the end users of health care services, consumers, are not usually directly involved in the cost/benefit decisions in health care spending. Traditional insurance by its very nature has shielded both consumers and health care providers from the economic consequences of their health care choices.

In the normal marketplace, when consumers spend money, they seek the greatest value for the products being purchased. They purchase based on price and quality, that is, value. The same incentives are needed for health care coverage to provide the ability for consumers to choose between competing managed care systems. By empowering consumers, the system will become more efficient. Consumers will have a powerful tool in the free market enterprise -- the power of the purse.

Basically, the Consumer Choice proposal utilizes a progressive tax credit to make a comprehensive benefit package accessible to all. It maintains the connection with the workplace and does not cause any economic disruption. In addition, because it uses the tax system, no new government bureaucracies are needed.

Specifically, the tax credits, which can only be used to purchase health insurance, are distributed as is shown in the Table 1. This tax credit is progressive, with the size of the credit geared to pay 100% of the estimated cost of a standard health care benefit package for those below the poverty level and scaled down until it provides 50% of the cost of health care for families with incomes over $100,000.

TABLE 1

PROGRESSIVE TAX CREDIT

Family Income	Tax Credit	% of Premium
$0 - $13,359[1]	$3,400	100
$13,360 - $26,718	$3,060	90
$26,719 - $49,999	$2,890	85
$50,000 - $99,999	$2,210	65
$100,000 and above	$1,700	50

Source: Center for Health Policy Studies Columbia, Maryland

[1] Poverty level for family of four.

This progressive tax credit reverses the current system. The way the system works today, high income individuals are benefited from the fact that there is a hidden tax subsidy for health care benefits. Currently, employees do not pay taxes on the value of the health benefits paid for by their employer. This is a perverse tax since it benefits the wealthy who otherwise would be taxed at higher rates. The total value of the subsidy is estimated at about $65 billion nationally and more than $1 billion in Maryland.

Consumer Choice corrects this inequity. (Table 2)

Under Consumer Choice, health care benefits are taxed, but the value of the progressive tax credit is calculated to offset these taxes in such a way that most families earning less than $50,000 in income stand to gain from this proposal. Those who earn more than $50,000 will have to pay more than they do now. However, it is anticipated that employers, who currently offer health insurance will want to continue to cover the higher income employees for competitive reasons. Under this assumption even individuals at the $100,000 of family income level break even compared to what they pay now.

TABLE 2

FINANCIAL IMPACT OF CONSUMER CHOICE HEALTH PROGRAM ON REPRESENTATIVE FAMILIES

	Net Cost Impact	
Family Income	No Employer Contribution	With Employer Contribution
$12,000	1,200	1,200
$25,000	422	713
$48,000	28	421
$75,000	(675)	156
$100,000	(1,100)	(12)

Source: Center for Health Policy Studies
Columbia, Maryland

Currently, employers do not have to offer health care insurance for their employees. Under Consumer Choice, employers would have to offer both a standard and a more comprehensive insurance package to their employees, but as is the case now, there would be no requirement that they pay for it. They would, however, pay a 4% payroll tax. Those employers who currently offer health insurance pay approximately 8 to 10% of their payroll for that purpose. Thus, they stand to benefit from Consumer Choice.

To protect the consumer, insurance carriers would have to be certified as qualified carriers. They must be fiscally sound and their administrative costs will be capped. They will also have to demonstrate that they have the capability to manage care effectively.

The presence of the tax credit will exert tremendous pressure on insurance companies. Consumers armed with a tax credit will search out those companies that are able to keep their premiums at or below the level of the tax credit. In effect, a target will have been established.

These qualified carriers will offer standard benefits packages similar to Blue Cross and Blue Shield of Maryland's comprehensive benefits package. Such a package would encourage early intervention and wellness and would include preventive and primary health care, hospital coverage, laboratory/diagnostic care and catastrophic coverage. Issuance of the standard insurance package would be guaranteed without regard to health conditions. Individuals would be free to move from job to job without fear of losing their medical coverage.

In addition, under Consumer Choice, the acute care portion of Medicaid would be folded into the program. Accordingly, current Medicaid recipients

would have benefits similar to everyone else. What is truly important here is that all citizens, no matter what their income, will have the same choices for health care and the same access to it. There will no longer be a two-tiered system for health care coverage.

Providers will negotiate with qualified carriers as they now do with insurance companies and HMOs. The providers who offer high quality care in an efficient manner will benefit and pressure will increase for providers to change practice patterns in order to be included in preferred provider organizations.

A major benefit of Consumer Choice is its cost containment mechanisms. It utilizes free market forces, rather than forced provider rate setting, to contain costs. Forced rate setting has proved to simply reinforce the current cost-shifting that has added to

TABLE 3

FINANCIAL IMPACT OF CONSUMER CHOICE HEALTH PROGRAM ON COUNTY/STATE EMPLOYERS

	Estimated Net Savings Under Consumer Choice (millions)
State of Maryland	$50
Baltimore City	$25
Baltimore County	$10
Anne Arundel County	$4
Carroll County	$1
Cecil County	$1
Queen Anne's County	$1

[1] Assumes that government employers will conservatively save 25 - 40% of their current contributions toward health care premiums for their employees.
[2] Actual savings will be a function of decisions by individual employers regarding contributions for their employees.

today's escalating health care costs. Under Consumer Choice, cost containment is addressed through aggressive managed care. Additionally, administrative efficiencies would be achieved through the elimination of medical underwriting, use of common billing forms, and the elimination of cost-shifting designed to recover uncompensated care costs.

There is also a major economic benefit to the economy and in particular to states and to local governments. As I indicated before, employers who currently offer benefits stand to gain under Consumer Choice. State and local governments are major employers. A conservative estimate of the cost savings to the State of Maryland and some sample municipalities, for example, are included in Table 3.

One issue of great importance is how all of this is financed and how Consumer Choice can be budget neutral. The answer is that there truly is enough money in the current health care system to give access to all. The problem, to date, is that the dollars have not been allocated to achieve this goal. Sources of funding of Consumer Choice include the following:

- Health care benefits would be subject to individual income tax;
- All employers would participate financially through a 4% payroll tax;
- Corporate taxes on gains in income would be realized as employee tax credits reduce the level of employer expenses for health benefits; and
- Federal and State acute care Medicaid funds and other public funds currently spent on the health care system would be applied to the program.

Using Maryland as an example, funding of the tax credit is shown in Table 4.

That's an overview of Consumer Choice. While on the surface this may appear to some to be similar to President Bush's proposal, probably the most significant similarity is that both plans use two of the same words -- tax credit.

The differences, however, are many. Consumer Choice applies a tax credit to everyone as opposed to individuals and families with certain incomes. Health benefits are taxed. The funding is far different as well. Consumer Choice does not touch the Medicare system. It does, however fold Medicaid into the total system.

TABLE 4

CONSUMER CHOICE HEALTH PROGRAM
Funding of Tax Credit in Maryland
(Millions)

TAX CREDIT COST		$4,740
INCREASED INDIVIDUAL TAX REVENUE[1]	$1,043	
PAYROLL TAX OF 4.0%	2,600	
INCREASED EMPLOYER TAX REVENUE[2]	472	
REALLOCATED FEDERAL/STATE MEDICAID DOLLARS[3]	345	
REALLOCATED HOSPITAL UNCOMPENSATED CARE DOLLARS AND OTHER REVENUE SOURCES	280	
TOTAL FUNDING SOURCES		$4,740
STATE BUDGET IMPACT		0.0

Source: Center for Health Policy Studies
Columbia, Maryland

[illegible]
[illegible]
[illegible]

The issue of health care reform is not a partisan one. Finger pointing has caused more problems than it has solved. True solutions are vital now. The fact that Senator Mikulski and others are taking the time and putting forth the effort to address the issue of health care coverage is significant.

I urge the Congress to support funding for state demonstration projects to test approaches for universal access. Testing is important because of the dramatic changes that potentially could occur with a significant part of the economy. When other countries moved to a form of national health , health care spending was approximately 3 to 4% of the GNP. Ours is now in excess of 12%. We cannot afford to make errors that would impact our economy in a negative way.

Is Consumer Choice likely to work? Yes, I believe it will. The potential for success has been demonstrated through the current Federal Employees Program (FEP) which is structured like the Consumer Choice Program. The FEP has been successful and offers over 400 plans to federal employees in a cost-effective and efficient manner.

Let me end by quoting Franklin Delano Roosevelt, who said: "The test of our progress is not whether we add more to the abundance of those who have too much; it is whether we provide enough for those who have too little."

A Consumer Choice type approach will do just that in the health care arena.

Thank you.

Elizabeth S. Morrison

Senator Mikulski, thank you for giving me the opportunity to participate today.

My name is Elizabeth S. Morrison. I am Vice President of Financial Services, W F Corroon - Herget Division in Baltimore, Maryland.

I have 14 years experience in the insurance area as a broker responsible for finding life, health and disability insurance for my clients.

I have been active in health legislation, both at the local and national levels and helped develop the Maryland legislation which extended health benefits to employees prior to the COBRA legislation. In addition, I am the current Health Representative for the Maryland State Life Underwriters.

I think I am in an unusual position here today in that I am not financially impacted by any change in legislation, yet I deal almost daily with clients -- employees and employers -- seeking help with their health insurance.

As a result of my 14 years involvement, I am convinced of the following:

Healthcare is a multifaceted problem of access, cost and quality of care. Previous attempts at curtailing costs have simply resulted in cost shifting.

Since there is untold legislation focusing on access, and I am not a physician, I plan to spend my allotted time today focusing on that part I know most about -- the second component -- cost or to be more exact, spending for healthcare.

Health insurance as we know it is only about 50 years old. Before WWII, consumers paid almost all healthcare costs out of their own pocket. During WWII, when wages were frozen, employers found they could reward their employees through increased benefits which were not frozen. Since purchase of benefits was more cost effective in large amounts, it was natural that healthcare would become most available through employer-based groups. Before 1940 only about 3 dozen insurance companies sold health insurance. 10 years later, over 200 companies were in the business. Tax laws played a very large part in the expansion of group employer-based benefits because they were a deductible expense to employers.

Now we arrive at the 1990's -- with expenditure on healthcare out of control.

As a community, we spend more annually on healthcare than any other industrialized nation and it is beginning to seriously impact our ability to compete economically on a global basis.

For all our spending, we are not the healthiest nation, we do not live the longest, 35 million of our citizens have limited or no access to basic healthcare, and our infant mortality is 50% higher than Japan. -- Clearly the system as we now know it is not working.

A lot of quick fixes have been tried. Insurers have shifted from community-based rates to experience-based rates, then to pooling smaller employers into trusts or like groups, then to offering guaranteed issue coverage only to employees of a certain minimum size group -- and most recently to the requirement of medical underwriting even to participate in an employer group health plan.

Each of these adjustments has reduced the risk pool; forcing employers to encourage employees with health problems out of the group and into various open enrollment options; forcing employees into "job lock" where they must stay with their current employer at all cost because it is the only way they can hold onto their healthcare plan.

All of these steps are exclusionary; none gives people better quality care or lower cost or expands coverage to those who don't have health insurance.

Many studies and much research have gone into examining the current delivery of healthcare in America.

Regardless of the plan we adopt in the future, there are several areas that seem to be specifically in need of change.

1. WHATEVER PLAN WE CHOOSE MUST OFFER BASIC COVERAGE TO EVERYONE.

This means incorporating the currently insured, the uninsured, Medicare, Medicaid and Worker's Compensation coverage.

81% of the uninsured are employed or dependents of employees. The vast majority of the uninsured work for small employers who do not have the preferential tax benefits of the larger employer. Healthcare costs can comprise up to 40% of an individual employee's total benefit package in a very small company -- yet average only 16% of the total benefit package for an employer of over 100 employees and only 5 1/2% of the benefit package for companies with over 10,000 employees. Creating guaranteed access to coverage will help, but if the coverage is still too expensive, it won't accomplish much.

Small employers say that even if access is guaranteed, they simply cannot afford the new plans unless they are significantly less expensive than plans now available privately.

In addition, smaller employer plans are notably less generous with benefits and often require a high participation percentage which smaller employers can't reach.

Over 23 states now have passed legislation allowing -- or requiring -- insurers to offer low cost basic medical insurance plans to small employers. 17 more states currently are considering such plans. Both the HIAA and the NAIC (National Association Insurance Commissioners) have advocated guaranteed access to coverage without penalty for pre-existing conditions.

However, a large number of state plans have not been the success that was anticipated at their start. In 1990, when Virginia announced their plan, they expected to attract a large number of the approximately 350,000 uninsured Virginians. By February 1992, only 27 small employers had signed on. Many small employers are concerned about the state plans high deductibles, high copays and limited services. In the long run, they do not see these plans as much value to them. States such as Florida, where large companies as well as small employers banded together, have apparently had more success.

The problem of healthcare costs for employers is now so extreme that some employers are offering cash to employees not to join their plan. Other employers offer bonuses ranging from $500 - $1,000 a year to employees not to put dependents on their plan. While many of these bonuses are legitimate savings to avoid duplicate coverage on two employed members of a family, some bonuses are incentives to eliminate an ongoing employee medical liability so that the employer can move the entire plan to a less expensive carrier.

2. WHATEVER PLAN WE CHOOSE MUST BE A COORDINATED PLAN.

We have a fragmented system which results in high cost of delivery of healthcare.

Insurance companies are still faced with coordinating 50 different plans in 50 different states and a total of 992 mandated benefits. Maryland leads the nation with 35 separate mandates. It is generally agreed that mandated benefits add 10% - 20% to the cost of healthcare premiums. However, those who fought long and hard for benefits such as mammography long before it was included under federal law, are loathe to accept any plan which eliminates mandates unless the replacement plan covers such items as well-baby care, etc.

In the past, large employers have been able to avoid mandates by simply moving to self-insured plans. However, no longer is self-insurance the exclusive territory of the very large employers. More than one-third of employers with 250 - 500 employees now self-insure. Over 88% of all self-insurers have modified their health plan in the last 3 years to control costs.

Numerous cost-cutting measures have been implemented especially in the area of managed care. HIAA data shows that in 1990, average HMO costs per employee were $2,683 while the PPO plan per employee cost $2,952 and an average indemnity plan per employee cost $3,214 annually. In 1990, 82% state governments and 54% city governments offered HMO options to employees.

The mixture of indemnity plans, HMOs, PPOs, etc. adds to the burden of paperwork. Other countries with more centralized systems have half the administrative costs we have. HCFA estimates $34+/- billion was spent in 1991 on general administration, utilization review and processing claims.

Private insurance carriers say that all the technology is in place to move to total electronic billing within the next 5 years at savings of millions of dollars annually. Over 450 different claims forms can be standardized for enrollment, billing, etc. resulting in faster payment, clearer understanding of care giver and better confidentiality of patient records.

Electronic billing would also substantially reduce the opportunity for fraudulent billing which is presently estimated to cost approximately 10% of insurance premiums paid. The National Health Care Anti-Fraud Association presently has over 380 members composed of private insurance companies, Blue Cross and Blue Shield organizations, healthcare reimbursement organizations, and state and federal law enforcement and regulatory agencies. They are working together to reduce fraud and eliminate schemes which inflate medical claims.

Another area of fraud is the increased misuse of Worker's Compensation. By not dealing with the 34+ million uninsured, many employees without coverage are going through the back door of Worker's Compensation to receive care for health problems unrelated to the work site. Worker's Compensation has no deductible, no benefit period and no managed care so it's vulnerable to extended misuse.

3. WHATEVER PLAN WE CHOOSE, WE MUST ELIMINATE THE OPPORTUNITY TO SHIFT COSTS.

Until recently the cost of healthcare was roughly shared equally by the federal and state and local governments. However, in recent years, due to legislation requiring balanced state budgets, any increases in spending on healthcare has had to be balanced by increased state taxes. As a result, for the past 5 years the combined spending by states and local governments has stayed fairly constant at about 13.5% while federal spending has increased from under 13% to over 15%.

In our system, we have preadmission hospital procedures; we examine patient bills, the insurer checks the checker who checks the checker. All of this adds to costs, yet offers no additional healthcare benefits.

New studies show that while managed care can show modest reductions in hospital admissions, instituting extensive employer-based plans actually have cost large employers more dollars than dollars saved.

Other countries monitor the providers rather than the patients or the procedures. They review physician results by geographic regions.

Cost shifting runs the gamut. One obvious example is transferring costs sustained by emergency room care for the uninsured to bills paid by those people who carry insurance. As a country, we absorb over $27 billion annually in expenses of the uninsured. Inner city hospitals are going broke because we have finally reached the point where the unreimbursed costs can no longer be added to the bills of the insured.

We are also seeing a new type of cost shifting where outpatient procedures are costing the patient more than the same procedure would cost on an inpatient basis. This cost shifting is taking place because inpatient expenses have caps not extended to outpatient procedures.

4. WHATEVER PLAN WE CHOOSE MUST CURTAIL UNNECESSARY MEDICAL TREATMENT.

Recent studies of inappropriate or unnecessary medical care are adding to the frustration we all have about healthcare costs.

A 1991 Milliman & Robertson study cites 53% unnecessary hospitalization nationally. New York, Chicago and Maine lead other cities with over 60% unnecessary hospitalizations each. Other national statistics cited are an average 15% unnecessary outpatient services, with Los Angeles at 36% unnecessary outpatient services.

While these numbers are certainly disturbing, I can't help but relate them to the problems I hear from physicians here in Maryland who are trying to keep an elderly patient in the hospital an extra day because he or she lives alone and can't manage if sent home too soon. Extra hospital days may not be the appropriate answer, but clearly spending on medical care is inextricably interwoven with the social issues facing our society for which we have not found answers.

Shock trauma centers now routinely save people who previously would have died without hi-tech medical procedures. As a society we have yet to deal with the huge cost and life-long care often attached to these cases.

We spend enormous amounts of money on saving premature babies. The U.S. has over 375,000 drug exposed babies, at an estimated 5 year medical cost of $63,000 each. Low birth weight babies cost us $2.6 billion annually, but at the same time, we are unwilling to fund WIC programs.

These are not problems that will be solved by offering insurance plans to small employers. These very expensive problems will only be addressed when we, as a nation, decide that the cost of withholding basic healthcare is more costly than offering it to all our citizens.

Other areas that add to the high cost of medical care include defensive medicine to protect against suits. Malpractice insurance now costs obstetricians over $35,000 annually. An attorney friend of mine called over a dozen OBs before she could find one that would accept her as a patient -- so pervasive is the fear of suit.

All of these are significant areas which add to the overall spiraling cost of medical care. Yet they do not impact the real base-line problem of providing basic care to all Americans.

PROPOSED SOLUTIONS - Numerous plans have been put forth, 3 major ones include universal care, play or pay and consumer choice. National organizations are also offering their own proposed solutions. I will just mention three:

The National Association of Health Underwriters has developed an eleven point program that includes support for 100% tax deduction of premiums, risk pools and elimination of state mandated benefits, limits to medical malpractice awards, uniform funding for hospitals, disclosure of medical service costs and cost containment through managed care.

Patrick Rooney, President of Golden Rule, supports the concept of a medical IRA. Mr. Rooney bases his plan on estimates that 2/3 of all medical care spending is under $3,000 per person annually. Based on this figure, he supports a plan whereby an employer would credit $3,000 to an employee account and let the employee decide how it is spent over the year. If the money isn't used up, the employee would retain it and be able to add to it the next year. New employees would have access to short term interest free loans if they didn't have the necessary funds built up. Individuals who lost employment would retain their medical IRA and could use this money to pay their

healthcare premiums until they found new employment. Under this plan, paperwork would be drastically reduced because only expenses over the $3,000 amount would be billed to the insurance company. Amounts over $3,000 would be treated as normal charges over the plan stop-loss.

The Coalition of Health Care Reform, Dr. Henry E. Simmons, President, has developed an employer-based play or pay proposal that includes formation of a National Health Review Board, reforms in cost control, malpractice and administration among its many suggestions. This bipartisan group which includes Republicans, Democrats, representatives of business and labor, as well as Presidents Ford and Carter, has spent over 18 months developing a significant plan which I feel deserves our serious attention.

Everyone agrees that the more involved the individual is with his own care, the more effectively his dollar will be spent.

I believe the final plan should include the following:

1. It should be a master plan requiring participation of all states.

2. It should incorporate uniform rate setting. Delivery of services should not be discounted with the expectation that the loss will be made up in other sectors. Realistic costs must be set and charged to all. Credits can be applied for those who cannot pay.

3. Birth defect suits should be carved out and settled by a panel of representatives from the medical community, insurance companies, citizen representatives and lawyers. Structured settlements based on need and payable for the life of the annuitant only are now being implemented by the U. S. Dept. of Justice in conjunction with DPT litigants. The same process should be used in case of birth defects.

4. Attorneys fees for litigation should be structured with a sliding scale maximum, similar to federal estate tax scales currently in use.

5. Doctors should be encouraged to practice general medicine through the use of scholarships in medical school.

6. Physicians should be required to update training on a regular basis.

7. A National Standard Practices Board should be created with a price structure for basic procedures adjusted by geographic region.

8. Procedures should be reviewed by geographic area and by physician result. Results should be readily available through computer access.

9. Premiums for medical coverage should be charged on a sliding scale, based on income.

10. Incentives should be incorporated into employee premiums based on good health behaviors, e.g., non-tobacco use, lowered cholesterol, use of seat belts, active exercise programs.

We must understand that our current patchwork system is holding us back from being economically competitive on a global basis. We must understand that healthcare spending is tied to societal problems caused by many problems, including the breakdown of the family unit, drug usage, lack of support for education reform.

As a nation, we must accept the premise that basic healthcare is a right of all our citizens and the cost of withholding this basic right will be far greater than our ability to pay in the not too distant future.

I thank you for the opportunity to participate today.

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Don Hillier
MNC Financial,

I'm glad I'm not a politician, for a lot of reasons.

- One is that legislators like Sen. Mikulski are doing a much better job than I could do.

- Another is that our citizens want to complain about the things that impact their lives, like the economy, unemployment and HEALTHCARE, and they want them FIXED, but they and the press won't let candidates for major office present their ideas as a basis for whom to elect. The focus instead is on who is "slick" or who bounced a check.

One of the big anticipated issues in this campaign was healthcare reform. It hasn't been in the forefront so far, I hope it will be in the future. But campaign issue or not, it's a BIG ISSUE for our country. At 14% GNP and a cost that will be at $1 Trillion in 2-3 years, it affects every aspect of American life including our international competitiveness.

And yet, it doesn't serve us well. There are 40 million uninsured, and our national health (life expectancy, infant mortality, etc.) ranks low in comparison with other countries. It does an outstanding job in some respects, but a poor one in others and the sum total is disappointing. No other developed nation spends as much and achieves so little.

So a consensus has finally developed - the current structure is too flawed to be easily "fixed", it must be restructured to provide MORE CARE TO MORE CITIZENS at LOWER COST. If every other developed nation can provide good care for ALL its citizens for 9% of GNP or less, we can too.

At last count there were 7,281 different reform proposals, with more being developed. I won't pretend to know all about them, but there are some general things I look for in reviewing proposals - both from the perspective of someone who's been involved with many aspects of healthcare for quite a while and from the perspective of the person responsible for the self insured medical plan of a large corporation.

1) It should be based on a national health policy. The policy should be no more than 2 pages long, should address access and expenditure levels.

2) It should provide healthcare to every citizen. Maryland provides hospital care to all citizens, yet hospital costs are lower than neighboring jurisdictions. This proves that universal access doesn't need to cost more.

3) It should save money. Most proposals either admit they will cost more than we are spending today and bemoan the lack of a way to come up with the extra funding; or they claim to save money/be cost neutral. Comments by "experts" then point out the flaws in the numbers and state that the proposal will actually increase costs. So it seems that while the purpose of most bills is to address cost and access, cost is sacrificed in the name of access. But it doesn't need to be, as I just pointed out in the case of hospital care. We can have both, but it won't be easy. If I were writing legislation my approach would be as follows:

A. Many developed nations provide excellent healthcare with better outcomes for all citizens at a cost of 9% or less of GNP.

B. We can too. Its not necessary to be cost neutral, we are spending too much and much of the excess is waste and inefficiency.

C. If we are now spending $800 Billion a year which is 14% of GNP, 9% of GNP would be $515 Billion, a savings of $285 Billion in today's dollars.

D. Any proposal must satisfy both requirements. Universal access at a cost of no more than 9% of GNP. These would be the cornerstones of a national policy and a yardstick against which to measure proposals.

E. "But quality will suffer", etc! Nonsense. Quality is just as good/better in countries "scraping by" on 9%. The difference is not quality, its efficiency, charges, utilization, etc.

F. The proposal must be compatible with the American culture in 1992. Proposals that would put 1499 of our 1500 health insurance companies out of business are not.

G. The proposal must effectively contain costs, not only initially but in the future. The Canadian system we talk so much about costs a little less than ours, but is growing at the same rate. Most U.S. proposals I've seen are very weak in this area, and would wash away some very effective cost containment initiatives developed by employers and state/local governments.

H. A recent survey done by Towers Perrin also shows that benefits professionals in primarily large corporations also favor:

1. Tax incentives to encourage small business, self employed and other uninsured to purchase health coverage - 77%.
2. Managed care for all including Medicaid (77%) and federal pre-emption of state laws that restrict managed care (65%).
3. Federal Pre-emption of state mandated benefits - 62%.
4. State insurance law reform - 70%
5. Reform medical malpractice laws - 93%
   and tax reform - 84%

They also oppose making some or all of benefits contributions taxable by 72 - 92%.

I don't have "The Answer". If I did, I would sell it. As I see it, a national solution is needed, but unlikely anytime soon. That means to me that we must do incremental things on a national scale such as adopting RBRVS principles for all payors, and the ones just mentioned, while using several states as laboratories - like Oregon and Maryland - to develop approaches that can be applied nationally.

We must move quickly - we are out of time.

MARY K. AMELING FREE STATE INDUSTRIES, INC.

The health benefit crisis is an issue discussed almost daily in my office. This discussion is not because we enjoy talking about health issues. or that we have nothing else to do. But rather it is always, "What are we going to do? We can't go on continuing to pay these outrageous rates not as a company nor as individuals."

Let me briefly tell you what has occurred in my company over the past 6 years.

Prior to Dec of 1986 Free State was owned by a publicly held manufacturer with a work force of over 750 people. The health benefit package was wonderful. Not only in its coverage but an individual paid no more than $20 maximum per month.

In Dec of 1986 we became a privately held company. Our employees numbered 26. Because a sale is often very traumatic for ones staff, we felt compelled to maintain the level of health benefits supplied by our previous owner. One immediate problem arose. The rate one gets when one is a small business vs a large business is outrageously different.

In our search we finally settled for the old faithful well-known Blue Cross/Blue Shield. They gave us a rate which amazed us and FSI was able to still only charge a very minimum to each employee.

In Dec of 1987 it was renewal time. We expected an increase but were stunned by what arrived on my desk. A 64% increase. We assured ourselves that had to be wrong but conversations with our BC/BS agent only confirmed the increase.

Our search for health insurance began again. This time we chose an HMO/PPO plan. Why? Still in an attempt to keep benefits and cost to as close to the old level as possible.

The HMO proved great for all who lived in the Baltimore area. But what about all of those employees in VA, So. MD. & the Eastern shore? The HMO benefits were null. It just wasn't equitable for all.

For several employees, the cost to the HMO was hugh. Why? Employees who rarely had gone to doctors because of out of pocket expense were now there once a week having every part of their body checked and rechecked. What a ridiculous waste of health care money.

As the year drew to a close we were once again on a mission to find health care benefits that were affordable, and had necessary coverage.

This time we chose to be self-insured. Why??? cost savings and yet the benefits were there. We chose an administrator who was small but supposedly well-recognized in the area. What a disaster this proved to be. It may on a monthly basis have been cost effective but when one figured in the time I spent talking to doctors, reconciling the account & talking to the administrator, the cost went over the hill.

At 1989 renewal time we switched to a different administrator. Why? We had searched the health market and still self-insured was the only way we could afford to go. We could only pray that our 1988 problem was the administrator.

We were proven wrong again. The new people were better at first but then fell right down the stairs. I constantly received calls from doctors for non-payment or rejection of claims.

In 1990 when renewal time came good ol Blue Cross/Blue Shield presented the best plan. Was I a sucker to go back? The answer is probably "yes" but I knew what they would do and, of course, to get us back a wonderful rate was granted us. My sanity was at stake as well.

However, because business was still not where it needed to be we had to change the way we were charging the employees. We changed from 80% payment by FSI to payment for employees only. Everyone was happy because they were back with BC/BS and the cost to FSI was not their concern or problem. I could now conceivably spend time on the problems of the company and the economy. (Remember in December of 1990 we were in a recession as well as fighting a war miles away.)

1991 renewal time arrived with Blue Cross/Blue Shield presenting a 34% increase even though our claims were under the total premiums we had paid for the year. Back to the drawing board again for health insurance. FSI could not possibly continue to offer the level of coverage which we had hoped nor could we continue to fund as much as we has previously.

But another problem arose. How could we place the burden on our employees? After all, in Jan of 1991 we laid off 20 people (reducing our force from 70 to 50), put a freeze on wage increase, cut out the majority of overtime and gave any one from a supervisor to the Chairman of the Board a 5-15% reduction in salary and no idea as to when these cuts might be restored. How were we now going to ask people who previously paid as little as $20 per month to pay over $300 per month to maintain the level of coverage they had had for years.

What was our answer? A medically under-written plan coupled with a cafeteria plan so each individual could determine what coverage they could afford. Is it fair? Is it equitable? By no means but I had no other choice. My company just couldn't afford any other way. As a company we also picked up a very minimum portion of each persons premiums. The salesman who makes $60,000 a year can more easily afford to have all the bells and whistles. But Little Joe who cleans the shop can hardly afford to have minimum coverage. His insurance if we had kept BC/BS would have cost him pre-tax one-fifth of his weekly wages. On my side as a small business owner I can't afford to pay the large premiums so he can have better levels of coverage which he can't afford to pay.

In presenting the new insurance I tried to get each person to review how much doctors, etc. would have cost the previous year if no coverage was available and to pick their level of coverage based on these facts, trying to get away from dollars earned. Almost everyone thought a prescription card was a must until they figured the cost of the premium vs what the medicines cost. I personally chose the lowest level. Not because I can't pay more but I'm going to bet my doctor bills are less than what I would have paid in premium. Still I pay $254 out of pocket for catastrophic coverage only for three people and it still only pays 70% of the bill if I go into the hospital.

We chose medically underwritten because we felt we were an extremely healthy group. Rates initially were given to be altered upon receipt of applications. The day after forms were submitted my husband had a heart attack. Do you know what that does to rates! Also, an employee with a "possible" need for a pacemaker was refused coverage. My husband was accepted, I presume because it was found his heart attack was extremely mild with no heart damage. However, this caused an increase of 13% on the previously quoted rates.

So you say, change the coverage, or don't cover your husband. That I could do but who made my people feel certain levels of coverage were necessary? Doctors and insurance companies. I go to see the GYN and for 15 min. I get charged $120.00. I have a cold, my doctor visit before medicine is no less than $50. I have a baby and I have to take it back every month for well-baby visits. I had fibroid tumors removed a year ago. A 3 hr. surgery had a doctor bill of $4000.00. Was the surgery really worth $4000? Obviously not as my doctor accepted as payment $1500, that amount exactly which BC/BS allowed. This same doctor has now changed his acceptance amount to $2500 but I can bet he'll submit much more than $4000 to the insurance company.

I can't as an individual afford these services without insurance but as a company I can't afford to pay so my employees can have these benefits either. My employees try to understand but let's face it as long as people see machines/merchandise constantly moving in and out of the yard they feel we are making all kinds of money. The large majority don't get involved with the personal property tax which is levied by each county, or the huge fines which get levied by DOT if found in violation, or the new laws enacted by our legislators on behalf of EPA. They don't think about the cost of electricity or the phone bill. These are just a given. They don't ask how much I pay just to cover my equipment incase an accident occurs and I end up in court. They only know that they need health coverage and I seemingly am responsible for supplying it.

Our state and nation need the small business person. But little by little each is being destroyed by laws saying we must pay such & such. There are many days when I wish I could call those who levy our laws and say "Why don't you come in and run my business for a month? You get to handle all the problems. You can talk to vendors who want to get paid in 30, 60, even 90 days. You can also talk to our customers who tell us why they can't pay us in 30, 60, 90 and more. You can talk to my employees about health costs and coverage and why I can't afford to fund as much as before.. You can write letters to our state and national representatives and tell them what it is really like in the real world of small business. It isn't fun right now and I don't know if the fun will ever come back. Certainly making changes in our health care system that cost the small business person more money isn't the answer if you want the small business person to continue to exist.

Having a health plan which mandates guaranteed ability to get coverage means absolutely nothing if I as a small business person can't afford to pay the premium and certainly means nothing at all if I am forced to close my doors because of lack of funds caused by government mandates. Yes, changes need to be made in our health care services but the victim of these changes cannot be the small business owner.

Dr. David Nagel - President of Med Chi

HEALTH CARE - INCREASED ACCESS
AND COST CONTAINMENT

Is it possible to have increased access to the health care system at less cost?

We all have heard the cry's, "Lets do something about our 35 million people who are uninsured," but we also have heard the cries from those who say, "Our health care costs are too high - we must change the system so that it will cost us less - or at least cost no more!

Some may say you can't have lower health care costs while providing more health care.

Now, to my point ...

How can we solve a problem if we can't identify it, which as we all know is the first step in problem solving.

For example, some legislators are ready to vote for the implementation of the "Canadian" Health Care System in the United

States. In the Canadian System all people are "covered" for health care benefits, thereby solving a part of the equation, that of access... However, some studies indicate that if the Canadian System were implemented today in the United States, there would be a cost of about $2,500 per American household beyond their current health care costs... I'd like to know how those studies were developed and the criteria upon which they were conducted.

And that's another point, rather than getting together to try to identify the real problem; with the exception of this kind of meeting today, thanks to Senator Barbara Mikulski, precious little is being done to try to identify the problem. But a plethora of solutions like the Canadian Health Care System are being cast upon the American people as the answer to our health care problems.

A recent news article, (Tracing Medical Costs to Social Problems - Washington Post, August 28, 1991) begins to shed some light on the problems affecting health care costs, such as the rapid rise in HIV cases and their concomitant rise in health care costs, some estimating more than $75,000 for each HIV case (for a lifetime of treatment)... or, the problem of some 375,000 drug exposed babies a much higher proportion than in Canada. These social problems are not the same as in other countries, indeed, violence in the United Sates is far greater then in other countries, with more than 20,000 homicides annually, some ten times higher than that of Great Britain or Germany and four times higher than that of Canada.

Even with this distinction between cost containment and increased accessibility (especially for the 35 to 40 million people without health insurance) a general approach is still needed - a plan if you will.

Perhaps we should look at developing some criteria for such a plan before we attempt to develop a solution.

The criteria of a workable plan should be:

1. It should aim toward a workable approach, not creating an ongoing test of public policy based upon who is the "stronger" elected official, Senator John Doe or Congressman Joe Smith.
2. It must avoid direct governmental micro-management - relying a great deal, on the

economic incentives demonstrated over the years between patients and their physicians.

3. It should not be considered the end all or panacea of the problem but rather an ongoing attempt to eat the elephant one bite at a time.

Most of you who are at least my age, may remember physicians as the kindly understanding gentlemen who made house calls and treated you even if you didn't have money or health insurance! How many of you remember those days? How many of you think those days are gone... gone forever...?

Well, let me tell you that the vast majority of physicians in Maryland still see patients without compensation. In fact, a recent survey indicated that 20% of the physicians in Maryland see Medicaid patients regularly and do not bill for their care! One reason for this is that a physician is only paid $10.50 per day for caring for a Medicaid inpatient and emergency physicians are paid $9.50 for a Medicaid emergency visit. The cost of submitting the paperwork exceeds the value received, and the pride of providing free care ... of assisting the less fortunate far exceeds all other considerations. Nationally, it has been estimated that physicians are providing free, uncompensated care amounting to $11 Billion annually to care for those who are uninsured!

Can health care services be delivered with high quality at affordable costs? and if so how?

Well, we can start by looking at the following:

1. Encourage health promotion and disease prevention. Both physicians and patients need to be encouraged to become more active participants in health promotion and disease prevention, including teaching the public about healthier lifestyles. Such activities favorably affect not only the extent and quality of life but also significantly reduce the cost of care. For example, one recent estimate indicates that 35% of all

hospitalized patients are there due to alcohol or drug abuse problems. Health-related problems due to other life-style choices, such as smoking, have been widely documented in recent years. Smoking is related to nearly 400,000 deaths each year in the United States, more than eight times the number of soldiers killed during the ten year Vietnam war.

2. Patients should be free to determine from whom and the manner in which health care benefits are delivered. Patients should remain free to choose their physician and their health care delivery setting.
3. Implement reductions in the administrative costs of health care delivery and the excessive and complicated paperwork nightmare faced by patients and their families who seek to obtain benefits.
4. Encourage cost-conscious decisions by patients. Insurance companies, employers and government programs should provide patients with clearer information prior to the service, of the cost of such care and more importantly what benefits the insurance plans will provide.
5. Reduce health care costs through malpractice liability reform which will reduce the need for defensive medicine, which as you know is the ordering of tests and procedures by physicians, that are not necessary for the diagnosis or treatment of the patient, and only tends to drive up the cost of medical services. It has been estimated that liability insurance premiums and defensive medicine add about 15% to the average physician's bill.

I believe I've used my time and once again thank you for your interest and you Senator Mikulski in your efforts to focus on this issue. As President of Med Chi I am proud to announce that the physicians of Maryland are dedicated to working with all interested groups in improving the quality of care and addressing the cost of such care for the citizens of Maryland.

ADDIE ECKARDT, M.S., R.N., C.S.
IMMEDIATE PAST PRESIDENT
MARYLAND NURSES ASSOCIATION

Senator Mikulski, panel members, colleagues and those who want to improve the health of citizens of Maryland. I am Addie Eckardt, RN, MS, CS, immediate past president of the Maryland Nurses Association and a resident of the Eastern Shore. Thank you for this opportunity to discuss nurses' perspectives on health care reform. I will describe positive elements of health care reform which are already in place in Maryland, and which have been implemented by nurses. The Maryland Nurses Association wants a health care system which improves access to care, quality of care and cost-effectiveness of care.

Maryland's 45,000 registered nurses deliver many essential health care services which assist people attain and maintain their health. We also deliver services which promote health and prevent disease. Nurses work in all health care settings: hospitals, nursing facilities, community/migrant health clinics, private practice and in managed care arrangements. Nurse also work in places where health care needs exist but which do not usually have health care providers present. These settings include schools, the work place and homes in all communities. Nurses are in these settings seven days a week, twenty four hours a day. It is this perspective which enables us to describe our vision for health care reform in Maryland.

The Maryland Nurses Association is one of 53 state and territorial constituents of the American Nurses Association. The ANA and seventy other nursing organizations representing 700,000 nurses have developed and endorsed Nursing's Agenda for Health Care Reform, a bold new plan for the health care system of the future. Since October, 1991, the Maryland Nurses Association and other organizations presented the first Maryland Nursing Summit for Health Care Reform. Nurses were invited to participate in this summit to

evaluate Maryland's health care needs in light of Nursing's Agenda for Health Care Reform. Findings from the Summit are integrated in this presentation. Maryland has an active coalition of nurses working for health care reform. The coalition will continue to refine ideas and create an inventory of nursing's initiatives which have promise for health care reform. We will do this through town meetings across the state to listen to consumers and to crystalize nurses' ideas about the problems, opportunities and solutions required to meet the health care needs of Maryland.

Nurses are frequently the first and sometimes the only point of contact for the consumer with the health care system. However, restrictive reimbursement policies have aggravated the legacy of an illness-oriented, hospital-biased and health care provider-focused health care system. Nurses recognize that there are many stakeholders who benefit from continuing the current system with only minor modifications. We are firm that one reform which must occur is the expansion of private and public insurer coverage to include the services provided by qualified nurses and other qualified non-physician providers. Expanding consumers' choice of primary care provider will reduce high cost physician office or clinic visits, reduce emergency room visits, prevent hospitalization and delay institutionalization. There are, literally, hundreds of studies which document improved quality of care and quality of life associated with expanded practice of nursing.

Maryland, because of its Medicare waiver, is the only state offering an all-payor system which assures access to hospital care by regulation of reimbursement rates. Acute hospital care operates in a fashion similar to public utilities. The Maryland Nurses Association believes this model has promise for other states and for a national health care reform plan. Facilities, especially hospitals, have worked hard in Maryland to reduce excess bed capacity, and to utilize services more effectively.

Acute care, however, is only one component of health care services. Ideally, to meet the complex needs of clients which vary in intensity across time, acute care is one of many which form a continuum of care services. The services may be given in the community or in institutions. Nurses are very versatile and can provide services in any setting. We believe that reimbursement for the services should not depend on the setting nor the employer, but should depend on the qualifications of the provider who renders the service.

Nurses in Maryland have found that by providing community-based services, health care can be provided earlier to vulnerable populations. Teaching and counseling by nurses prevents costly hospital care. There are mobile treatment teams in Maryland where nurses

act as clinical case managers for chronically mentally ill, treatment-resistant psychiatric clients living in the community. Health care services are coordinated by the nurse case managers. Through early intervention, prevention, teaching and counseling, costly long term psychiatric hospitalizations are reduced or avoided.

Another innovative example of allowing nursing knowledge to be implemented in non-traditional ways is a program which is meeting the needs of the homeless in Baltimore. Established by a group of nurse practitioners, "Paul's Place" is a model which fosters consumer responsibility for personal health, self care and informed decision-making about health care services. Efforts are directed toward reducing fragmentation of the present system of health, social, educational and vocational services, and creating advocacy for special populations.

Nurses are committed to the provision of health care throughout the life cycle. The nursing literature describes strategies such as nurse home visiting which are reducing infant mortality and avoiding the use of costly, high-technology services for low birth weight babies. The long history of public health nursing, in particular, has shown the wisdom of prevention programs targeting infant, preschool and school age groups. Outcomes of these programs include improved health, more consumer responsibility for health, better informed consumers and reduced use of costly health care services.

Maryland continues to have a regulated system of health care with the aim of providing quality, cost effectiveness, affordable and accessible care for all citizens. Nursing involvement with both the Maryland Health Resources Planning Commission and the Maryland Health Services Cost Review Commission is an example of how Maryland nurses are working to effect change within our system. The Maryland Nurses Association is committed to supporting and encouraging nursing involvement in all aspects of health policy and service delivery.....public, private, legislative and regulatory.

I would like to highly and support several key features from Nursing's Agenda for Health Care Reform which we believe are instrumental in effecting health care reform in Maryland.

First, we support universal access for all citizens, provided through a re-structured health care system. This system will provide a state-defined package of essential health care services financed through a public plan and employer-based private plans. A 1991 Maryland law defined a basic insurance benefits plan. Evaluation of the utilization and effectiveness of the implementation of this law will provide information needed for summer study in 1992,

and proposed legislation in 1993. A task force of the Maryland Nurses Association legislative committee members is closely monitoring the implementation of this law and its articulation with proposed legislation. There are thirty to forty thousand Marylanders who are uninsured. We do not have accurate data about the number of under-insured, periodically uninsured and seasonally uninsured, many of whom are women and children. Because of the complexity of needs, we do not feel an employer-provided health care system will have answers nor access for all citizens.

Second, the Maryland Nurses Association supports a shift in focus to provide a balanced distribution of scarce health care resources used to diagnose and treat disease, and the resources needed to promote health and prevent disease. The U.S. Preventive Services Task Force 1989 publication called The Guide to Clinical Preventive Services evaluated one hundred different interventions which were most effective in preventing sixty of the most common and troublesome diseases of our era. The interventions which are most effective in preventing disease are the teaching and counseling elements which have been part of nursing practice for many decades. Yet our health care system does not adequately support by reimbursement the teaching and counseling interactions necessary to help individuals make informed health care choices about diet, exercise, immunizations, effective parenting, coping with chronic illness, use of tobacco and other substances and many other aspects of the daily lives of Maryland citizens. We urge support of services which promote health and prevent disease.....services which nurse are uniquely prepared to provide.

Third, the Maryland Nurses Association supports enhanced consumer access to services by delivering primary health care in community-based settings. Maryland nurses are committed to delivering care where the health needs are and where the people are.....in homes, in schools and colleges and in the work place. Several pilot projects illustrate how nurses are implementing nursing knowledge in new ways. Several nurse educators are involved in a project that provides information on creating a safe environment for older citizens living at home. Nurse practitioners are providing health education and primary care services to high school children. Some of these children do not qualify for Medicaid nor are they covered under a parent's employer-based health care plan.

Fourth, the Maryland Nurses Association believes that several steps can be taken to further reduce health care costs.

- We firmly support requiring the utilization of managed care in the public plan.

- We believe that if consumers have access to a full range of qualified health care providers, including advanced practice nurses such as nurse practitioners, certified nurse midwives and clinical nurse specialists, aggregate health care costs will be reduced.
- We also believe that providing early treatment, prevention services and health promotion services at convenient sites such as schools and colleges, the work place, churches and other settings will increase access and make the current system of care more user friendly.
- We also believe that administrative costs can be reduced by implementing several elements of automated health records, such as electronic billing and uniform claims forms.
- We firmly support nursing case management (also called care coordination) for people who have continuing need for health care services. Currently, Maryland is expanding a case management model for the Committee for Children, Youth and Families.
- We believe that public and private funding for a comprehensive continuum of long term care services must be provided, while yet preventing personal and spousal impoverishment.
- We support several insurance reforms such as community-basing premiums and mandatory coverage of pre-existing illnesses.

The Maryland Nurses Association is assisting the American Nurses Association in the development of several "white papers" to flesh out Nursing's Agenda for Health Care Reform. These white papers will provide other examples of how the unique skills and knowledge of nurses can be harnessed to meet health care needs. We will be sharing with your office these "white papers" as they emerge. One on case management is completed; another on school nursing is nearing completion. Others will define essential mental health services, will examine ethics and human rights implications of health care reform and insurance reform, among others.

The Maryland Nurses Association and the Nurses' Coalition for Health Care Reform have begun an Inventory of Nursing Initiatives....solutions to problems of access and cost as we see them now in Maryland. We are pleased that Maryland has several positive elements already in place, elements which utilize nurses. Our task now is to move forward with individuals and groups to design a system to address the complex health care needs of our citizens.

We appreciate this opportunity to share our ideas and we look forward to continuing the collaboration we have enjoyed with you as we set about, together, implementing solutions to the health care crisis in the U.S.

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Esther Rae Bart, CAE
Executive Director

Statement of C. Earl Hill, M.D.
Field Hearing of the Senate Committee on Labor and Human Resources
Dundalk Community College
April 23, 1992

Madam Chair,

My name is C. Earl Hill, M.D. My statement is submitted on behalf of the Maryland Academy of Family Physicians. In addition, I am a member of the Board of Directors and Chairman of the Commission on Legislation and Governmental Affairs of the American Academy of Family Physicians. I would like to commend you for holding this hearing on Marylanders' views about health care reform.

As you know this month the AAFP released its proposals for assuring access to health care and strengthening our health care systems for all Americans. The AAFP plan is supported by the Maryland Academy of Family Physicians.

"RX for Health: The Family Physicians' Access Plan" would provide for universal access to health insurance and effective control of rising health care costs. Whereas many other health reform plans also offer strategies to assure access and control costs -- some similar to the Rx for Health Plan and some different -- ours is the only one to address comprehensively a major failing in our health care delivery system: the severe shortage of generalist physicians.

In most countries, at least one-half of their physicians practice in the generalist specialties -- family medicine, general practice, general internal medicine, and general pediatrics. In the U.S., however, over 70 percent of all physicians are subspecialists. A growing body of research literature indicates that this vast overspecialization of medicine in the U.S. is a key source of our problems relating to access, rising health costs, and concerns about the appropriateness and quality of care.

I would draw your attention to two recently published articles which are submitted with this statement. The first, authored by Barbara Starfield, compared ten nations on the basis of their primary care systems and found better public health outcomes and higher public satisfaction in nations where a generalist model of health care delivery predominates.

The second article, by Sheldon Greenfield, et.al. studied treatment patterns across medical specialties and found generalists to be far more cost-effective due to their prudent use of hospital services, tests, and expensive procedures.

These and other studies confirm what is already intuitively obvious to many of us. A system of health care delivery based on a generalist model makes sense. Patients need to have a well-trained generalist physician who is their ongoing source of health care, who can help them seek appropriate referrals to specialists when necessary, and who can ensure that all medical care is properly coordinated both to maximize the patient's health outcomes and to minimize costs. Unfortunately, in the U.S. today, while the vast majority of health care needs relate to primary care, the vast majority of our physicians are trained as subspecialists.

Without a sufficient generalist medical corps -- at least 50 percent of all physicians should be generalists and at least half of generalists should be family physicians -- our nation wil continue to be frustrated in our pursuit of meaningful universal access and effective cost containment. The recommendations of the Rx For Health Plan offer a comprehensive strategy for achieving and enjoying the goals of access and affordability:

* Our plan assures universal access to health insurance primarily through employment-based plans with a publicly sponsored plan providing health coverage for Americans not otherwise insured. Small employers and low income individuals would be eligible for subsidies under the publicly sponsored plan.

* Our plan provides for a basic health benefits package that would offer comprehensive coverage with reasonable cost sharing. Insurance reform would ensure that coverage is offered in a non-discriminatory manner and remains portable for people who change health plans.

* Our plan would control health care costs through a variety of reforms, including the establishment of a national health care commission authorized to set a global budget for health care spending growth in the U.S. each year. These spending goals would be implemented by Health Plans at a local or state level and could be met through managed care arrangements and other means. However, the national commission would have power to enforce spending growth limits in plans failing to meet national targets, if necessary, by controlling the growth in provider fees.

* To ensure meaningful access and affordability, our plan would promote various reforms to ensure that, over time, at least 50 percent of all U.S. physicians are generalists, and at least half of all generalists are family physicians. In particular, a redirection of federal financial incentives would reverse the tendencies of medical schools and residency training programs to train a surplus of subspecialists. Further reforms in federal student loan programs and in health care reimbursement policies would reinforce goal of increasing the number and proportion of generalist physicians.

* Finally, our plan would require all Americans to have a "Personal Physician," trained in family medicine, general internal medicine, or general pediatrics, so that the primary care model becomes a reality in this nation. To encourage participation in this model of care, health insurance plans would impose a coinsurance penalty on patients who seek non-emergency care from a subspecialist without referral from their Personal Physician.

Madame Chair, a complete copy of the AAFP Rx For Health Plan is attached with this statement. This strategy for health care reform is good for our nation and good for our state of Maryland. I very much appreciate your consideration of our proposals and look forward to our continued close partnership as we work toward a stronger, more humane health care system.

Attachments: AAFP Access Plan
Starfield Article
Kravitz/Greenfield Article

Rx for Health: the Family Physicians' Access Plan

A proposal by the
American Academy of Family Physicians

Summary of Major Provisions

Universal Health Insurance Coverage

Universal health insurance coverage must be achieved primarily through employer based plans, in combination with state-sponsored public plans which would replace Medicaid and provide coverage for eligible low income individuals and employees of small businesses.

Physician Specialty Distribution

A common cause of all our nation's health system problems — lack of access to appropriate health care, rising health costs, concerns about quality — is the severe shortage of well trained generalist physicians. Our overly specialized medical corps (with less than 13 percent general and family physicians) cannot manage care appropriately and tends to prescribe expensive subspecialty services unnecessarily. The foundation of any health reform strategy must include coordinated changes to achieve a physician specialty mix with at least 50 percent generalist physicians, at least half of whom are family physicians.

Basic Health Benefits

Federal law must define a basic health benefits package for all health plans which would assure comprehensive coverage while promoting cost effective delivery of care.

Cost Containment

An effective cost containment strategy must be adopted to assure affordability of insurance. This strategy must include private and public health plan intitiatives to better manage care, tort reforms, limits on administrative expenses, and a uniform payment system for providers. In addition, a National Health Commission must have authority to establish a global budget for health care spending, and to enforce spending goals, if necessary, by limiting provider payment increases or otherwise controlling expenditures under private and public health plans.

Quality

Quality of care must be protected and enhanced through a variety of reforms and research efforts.

Insurance Reform

Private health insurance reforms must assure all health plans are guaranteed issue, guaranteed renewable and community rated, and must protect the portability of basic health coverage.

Financing

The AAFP plan must not increase the federal deficit. The cost of reforms will be financed by resource reallocation and modified taxation strategies.

AAFP Position Statement on Access to Health Care for the Uninsured and Strengthening the U.S. Health Care System

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Introduction

In 1989, the American Academy of Family Physicians adopted a position in support of reform of our health care system to achieve universal access to basic health care services. The Academy remains committed to this fundamental reform. Since then, the number of uninsured Americans has grown and rising health costs have threatened access further. The Academy has been involved in the changing public policy debate of health care reform solutions. This document represents an evolution in our 1989 health care plan. It refines many elements of our earlier health care plan; it specifically addresses the problem of rising health care costs; and it underscores the need to address underlying problems of an overspecialized physician corps in order to achieve a more appropriate system of health care delivery grounded in primary care.

As the national policy debate on health care reform proceeds, the Academy will continue its active involvement and will consider further evolution in our proposals for reform. In addition, the Academy is in the process of developing more detailed proposals to finance universal access to health insurance as well as recommendations for ensuring access to long term care.

Statement of the Problem

During the 1980s and the early 1990s, there has been a dramatic increase in the number of Americans who are without health insurance. Estimates place the number of uninsured Americans at 38 million. Additional tens of millions are thought to be underinsured. While public opinion polls repeatedly have indicated widespread agreement that everyone has a right to adequate health care, those same polls evidence little enthusiasm for improving access through increased taxes. The dilemma, then, is how to address a societal problem of significant proportions — the lack of access to health care for millions of Americans — given our finite financial resources and a reluctance among both policy makers and the public to increase taxes to provide insurance coverage. Despite this dilemma the AAFP believes the issue of access to health care for the uninsured must be addressed as one of this Nation's highest priorities.

Affordability of health care is a major concern for all Americans. Although the U.S. health care system at its technologic best is the envy of the world, it has fallen victim to structural and financial barriers that hinder access to primary medical care and detract from the appropriateness and cost effectiveness of health care services. A key structural barrier is that less than 13 percent of American physicians are family physicians/general practitioners. By contrast in most Western nations at least 50 percent of physicians are family physicians or other generalists. An over-specialized medical corps is not trained to manage health care services and tends to promote overuse of expensive medical procedures and technology. Furthermore, our systems of reimbursing health care services create financial disincentives to the appropriate management of health care based on a primary care model.

While most insured Americans receive health coverage through employment based plans, fully 3/4 of the uninsured are employed or dependents of people who have jobs. Another significant segment of the uninsured population are the poor and near poor, who are not covered by Medicaid or other means tested public health insurance programs.

Small businesses, which employ a majority of uninsured workers, face particular difficulties in obtaining group health insurance coverage. Risk selection practices prevalent in the private, small group health insurance market today present an especially inappropriate barrier to obtaining health coverage. It is not uncommon for small employers to be denied coverage at any price due to the nature of their business (e.g., high risk, seasonal employment, health related employment, etc.) or due to a preexisting health condition of an employee. Insured small employers often have difficulty renewing coverage at an affordable rate once a member of the group has incurred an expensive claim. Furthermore, many small employers just entering business or with small profit margins find that the price of employee health benefits — risk selection practices notwithstanding — is a major barrier to access to coverage. For these reasons, small employers who otherwise desire to provide group health coverage for their workers and families are unable to do so without targeted assistance.

The Medicaid program conditions beneficiary eligibility on requirements that vary significantly from state to state. Much of the variability is based on different state definitions of eligibility for cash assistance. Less than half of those below the federal poverty level qualify for Medicaid benefits, and the scope of benefits also varies from state to state. Because Medicaid payments for services are substantially discounted, a two-tiered system has developed under which Medicaid patients' choice of providers are limited. Many do not have access to "mainstream" medical care. For these reasons, the Medicaid program does not present a viable mechanism for addressing the problem of access for the uninsured.

To summarize, our nation's health care system faces interrelated problems requiring systemic reform. Such reform must specifically and meaningfully address the issues of providing universal health insurance coverage, controlling rising health care costs, ensuring an adequate supply of appropriately trained health professionals, and maintaining quality of care.

Strategies for Solutions

It is the position of the Academy that the issue of universal access to affordable, appropriate health care can best be addressed through a system that is based primarily in the private sector. However, this system must also include a public sector insurance component for people not otherwise covered, and it must include significant structural and financial reforms to promote the delivery of appropriate,

cost effective health care services. Such a system should be based on the concept that all Americans have ready access to primary care services as well as appropriate access to more elaborate medical technologies. Furthermore, a reformed health care system should not be so complex as to undermine the ability of patients, providers, and insurers to understand it and operate effectively within it.

Under our approach, which would be phased in over time, all employers would be required to provide insurance coverage for basic health benefits (see page 13) for their full-time employees and their dependents. Employees would be required to participate in their job-based health plans. Individuals not covered by employer provided insurance would be covered under new, publicly-sponsored health insurance programs. To ensure the availability of basic health care services and the appropriate utilization of more elaborate technologic services, various reforms would be adopted to increase the supply of family physicians and other generalist physicians relative to other medical specialists. To ensure that health care would be more affordable, health care financing reforms and other measures to promote administrative efficiency would be adopted. Finally, reforms would be adopted to control the cost of health care services, but without sacrificing the quality of services delivered.

Recommendations

Consistent with the overall objective of providing universal access to appropriate, affordable health care, through a combined private sector/public sector effort, the Academy supports the following principles:

I. Employer Provided Coverage

(a) All employers would be required to provide health insurance covering the federally established basic benefit package for employees who work more than 17.5 hours per week and their dependents.

(b) Small businesses with fewer than 25 employees would be eligible to purchase health insurance from a state established public program (see II.(b), page 4), with the cost of such insurance based on a percentage of the employer's payroll. The payroll tax rate would be set to ensure a fair balance between private and publicly sponsored coverage for employees.

(c) Under the employer mandated coverage, the employer would be required to pay no less than a statutorily defined percentage of the employees' insurance premiums. Employees would be responsible for their portion of the insurance premium and for reasonable cost sharing.

(d) Federal standards would be established for qualified employer group health insurance policies to ensure adequate access to basic health care services necessary to prevent, diagnose or treat disease and injury. The federal standard for coverage also would ensure protection from financial catastrophe for covered individuals. Patient cost sharing would be structured to promote cost-conscious use of health services and to encourage early and unhindered access to preventive and other primary care services. In addition, cost sharing would discourage inappropriate use of expensive subspecialty services by patients without referral from their Personal Physician (see V.(b), page 7).

These federal health benefits standards (described in detail on page 13) would preempt state health benefit mandates for all employment based health plans.

II. Publicly Sponsored Coverage

(a) Each state would establish a public program that would replace Medicaid for covered services (described on page 13) and that would contract with private insurance carriers to provide health coverage meeting the same minimum standards required for employer sponsored plans. The state established program would be available to small businesses (see I.(b) page 3) and to those individuals not otherwise covered by employer sponsored plans or Medicare (see II.(b) below).

(b) Individuals not covered under employer plans would be required to enroll in the public program in their state. Uninsured persons failing to enroll would be deemed enrolled in the public program at the time they seek health care services. Financial assistance for premiums and cost sharing under the public plan would be available based on uniform federal guidelines. Persons with incomes at or below the federal poverty level would be wholly subsidized for their premium and cost sharing expenses. Individuals between 100 and 200 percent of poverty would be eligible for subsidies based on a sliding scale. Persons with incomes above 200% of poverty would pay the full premium.

(c) Payment for services under the public program would be at par with Medicare payment and would be established according to Medicare payment methods, including a resource-based relative value scale for physician services. The cost of the public programs (including the cost of subsidies for small employers and low income persons) would be financed through a system of state funds and federal matching grants with poorer states eligible for greater financial assistance.

(d) The new public program would not replace or change other public programs such as Medicare, military and veteran health programs, Worker's Compensation, etc.

III. Insurance Reform

(a) The private health insurance market would be reformed to achieve uniform coverage for basic health services, portability in health insurance coverage, stability in health insurance premiums, and administrative cost savings. Insurance reforms would apply to all health plans — those covering only basic services as well as those covering additional benefits.

(b) All health insurance carriers would be required to offer a plan covering only the federally established basic benefits package. In addition, health insurers would be permitted to offer plans with coverage in excess of the basic health benefits. Insurers would have to make all plans available under traditional indemnity and managed care options.

(c) All health insurance plans would be guaranteed issue and guaranteed renewable. No insurers would be permitted to deny, discontinue or condition coverage under any health plan based on the health status or claims history of the person or group applying for coverage. In addition, to ensure portability of coverage, no insurers would be permitted to exclude coverage under any health plan for pre-existing health conditions.

(d) All health insurance plan premiums would be determined according to community rating within defined geographic areas.

(e) To minimize the administrative expenses of health insurance and health services, all insurers would be required to use a uniform billing system and claim form, permit electronic submission and payment of claims, and meet minimum standards for timely reimbursement of providers.

IV. Physician Supply

(a) Congress must adopt national policies to ensure that, over time, at least one-half of all physicians in the U.S. are in general medical specialties (family medicine, general internal medicine, and general pediatrics) and, further, that at least one-half of all generalist physicians are family physicians. To achieve this goal the following reforms would be implemented.

(b) Federal financial incentives that discourage medical schools from emphasizing the training of generalist physicians would be reversed. Billions of dollars in biomedical research grants from the National Institutes of Health (NIH) constitute a significant revenue source for many medical schools. Competition for such grants encourages schools to divert resources and prestige to revenue generating departments in the medical subspecialties, while de-emphasizing departments of family medicine. This is evidenced by the fact that among the ten leading recipients of NIH competitive medical research grants in 1990, on average, only 7.3 percent of graduates entered residency training in family practice.

Financial incentives would be realigned to encourage medical schools to increase the priority given to training in family medicine, general internal medicine, and general pediatrics.

- Receipt of the indirect portion of extramural research grants from the National Institutes of Health (NIH) would be conditioned on the extent to which medical schools graduate a minimum proportion of students who become generalist physicians upon completion of residency training. The indirect portion of grants is paid to the medical school, not the

researcher, to compensate the institution for a portion of its overhead costs. For a specified interval, medical schools failing to achieve the minimum proportion should be exempted from reductions in the indirect payments if the school meets certain criteria related to encouraging more students to select generalist training. Criteria would include selective admission procedures, a formalized department of family medicine, and a required family practice clerkship of at least six weeks duration by no later than the third year of medical school.

- These requirements should be carefully designed and applied so that the direct portion of biomedical research grants and individual research efforts and agendas are not compromised.

- Federal matching grants to states for the public program would contain incentives to encourage medical schools to increase the absolute and relative numbers of graduates entering residency programs in family medicine, general internal medicine, and general pediatrics.

(c) Federal financial support for graduate medical education (GME) also would be realigned to encourage residency training of generalist physicians in more appropriate ambulatory settings.

- Medicare reimbursement for the costs of GME would be restricted to only the first three years of residency training;

- GME payment formulas would assign a greater weight to family practice and other primary care residencies;

- HMOs, clinics, and physician practices would be eligible for Medicare GME payments;

- Medicare GME payments would be restricted only to the training of residents in specialties in documented undersupply.

(d) Finally, federal financial incentives should encourage medical students and residents to enter generalist specialties and should encourage generalist physicians to remain in practice, especially in medically underserved areas. Accordingly,

- The time for repayment of medical school student loans would be extended for residents who enter practice in family medicine, general pediatrics, and general internal medicine. Additionally, interest payments on medical school student loans would be publicly subsidized during residency training in those specialties

- Physicians practicing family medicine, general pediatrics, and general internal medicine in medically underserved areas would be eligible for partial or entire student loan forgiveness.

V. Cost Containment

(a) A multi-faceted approach to cost containment must permit competition at the state and local plan level to pursue creative, negotiated solutions, while assuring that national goals for affordable health care services are met.

(b) All private and public health plans would seek to control costs and to enhance the quality and appropriateness of health services using a primary care model. Toward this end all basic health plans would:

- require enrollees to have a Personal Physician, who is a family physician/general practitioner, general internist, or general pediatrician, and who will serve as their source of regular and ongoing medical care. A requirement that the Personal Physician be in one of the generalist specialties should be phased in as the specialty maldistribution of physicians is corrected (for example, during the transition period, an obstetrician/gynecologist could serve as a Personal Physician;)

- incorporate patient cost sharing requirements to promote cost effective preventive services and to discourage inappropriate use of subspecialist services. These cost sharing requirements would include:

  - all covered services, except as specified immediately below, would be subject to a deductible of $250 per person, or $500 per family, and to 20 percent coinsurance;

- most periodic screening and evaluation and preventive care services would not be subject to a deductible, but would be subject to 20 percent coinsurance;

- prenatal and well baby/child services, including childhood immunizations, would not be subject to either a deductible or coinsurance;

- services rendered by the patient's Personal Physician would not be subject to a deductible, but would be subject to 20 percent coinsurance;

- non-emergency services rendered by physicians other than the patient's Personal Physician without referral from the Personal Physician, would be subject to an additional 20 percent coinsurance (for a total of 40 percent.) This requirement would be phased in as the medical specialty distribution is adjusted;

- total patient cost sharing (deductibles and coinsurance) would be limited to $1,500 per year per individual and $3,000 per year per family. However, the 20 percent coinsurance penalty for self-referred services would not apply toward or be limited by this out of pocket limit;

- incorporate established, outcomes-based clinical policies into plan practices;

- reimburse health providers using uniform payment methods, including a prospective payment system for hospitals and a resource-based relative value fee schedule for physician services;

- negotiate with providers to establish Component Performance Standards (as described in V.(e), below), including fee schedule conversion factors and appropriate utilization controls, that would achieve nationally established performance standards for aggregate health care spending growth.

(c) Federal standards would be developed to replace state laws regulating managed care and utilization review programs. At a minimum federal standards would

- encourage the development of financial incentives to promote appropriate referrals and cost effective delivery of health services;

- ensure that these financial incentives are not structured in such a way as to threaten the quality of care;

- ensure that managed care plans have a sufficient number and distribution of providers (by specialty and by geographic location) to assure enrollees of the timely availability of all covered services.

(d) Medical liability reform would be implemented to promote both the affordability and appropriateness of health care by limiting the tendency to provide "defensive medicine." Medical liability reform would provide for

- alternative dispute resolution systems, such as binding, fault-based arbitration systems;

- malpractice tort reforms, including limits on payments for "noneconomic damages," limits on attorneys' contingency fees, elimination of joint and several liability, reductions in awards by the amount of compensation from collateral sources, and structured payment schedules to replace lump-sum awards;

- use of federal funds to establish a risk retention group that would provide affordable liability protection to health care professionals practicing in community and migrant health centers; and

- strengthening of state licensing and disciplinary agencies to provide prompt remedial and/or punitive action when such action is warranted.

(e) A National Health Commission would be established for the purposes of determining national cost containment objectives and coordinating and reinforcing private and public efforts to achieve those objectives. State and local health plans would retain the ability to develop and implement specific cost containment mechanisms within the context of the broad objectives established by the National Health Commission (see V.(a), page 7). The

National Health Commission would be comprised of members representing large employers, small employers, patients, private insurers, states, and major providers of health care services (e.g., hospital, physician, prescription drug, etc.) At least half of the representatives of physicians on the Commission would be in the generalist specialties, and at least one of the generalist physicians would be a family physician. Duties of the Commission would include:

- collecting and disseminating data including profiling data and measures of the volume and intensity of health care services and factors that affect volume and intensity. In this regard, a high priority for the Commission would be to promote the development of measures of factors (such as epidemiological trends, poverty, etc.) that affect health care spending and that might warrant adjustments or exceptions in evaluating the success of health plans at controlling health costs;

- developing a uniform claims processing system to promote administrative efficiency and prompt payment for services by all health plans;

- establishing a national budget for aggregate health care spending. The global budget would be expressed in terms of an "Aggregate Performance Standard" rate of annual growth in spending for health care services. For example, the global budget for aggregate health care spending in 1995 would be the amount of aggregate health care spending in 1994 increased by the Aggregate Performance Standard rate of growth for 1995. The Aggregate Performance Standard would be established by the Commission annually;

- evaluating and enforcing compliance of state and local health plans with the national budget for health care spending and the Aggregate Performance Standard rate of growth;

- establishing performance standard rates of growth for each major component of health care spending (i.e., hospital, skilled and intermediate care nursing facilities, physician evaluation and management services, surgery, imaging, medical procedures, laboratory services, prescription drugs.) In general, these "Component Performance Standards" would be advisory. However, the Commission could direct a health plan to follow the nationally established Component Performance Standards to limit plan expenditures in a year when aggregate health care spending under that plan exceeds the rate of growth permitted under the Aggregate Performance Standard (see V.(f), page 10). Component Performance Standards would be established by the Commission annually;

- providing technical assistance to plans in order to

  - analyze data to determine the factors contributing to increased health care spending within each Component Performance Standard; and

  - develop remedial responses (such as targeted utilization review, prior authorization requirements, and the development of specific clinical practice parameters) to address those factors contributing to excessive cost increases.

(f) The relationship between state and private health plans to the national performance standard process would be as follows:

- The Aggregate Performance Standard for health care spending growth would be binding for all state and private health plans. To illustrate, if the Commission determines that aggregate health care spending should grow by no more than ten percent in a given year, all health plans must strive to limit growth in their per capita health costs (with adjustments for the age of plan enrollees) to ten percent.

- Health plans and their participating providers would be free to negotiate their own Component Performance Standards in order to meet the national Aggregate Performance Standard. For example, a health plan potentially could meet the Aggregate Performance Standard, even though its own Component Performance Standards differed from those set by the Commission, if that plan successfully employed a primary care model to manage care, reduce unnecessary hospitalization, and promote a more appropriate mix of health care services. In addition, a plan meeting the national Aggregate Performance Standard for spending growth could negotiate higher conversion factors or bonus payment arrangements with its providers.

- However, if a health plan's aggregate spending growth exceeds the national Aggregate Performance Standard, the ability to negotiate independently Component Performance Standards and fee increases with providers would be constrained. In such a case, increases in provider fees could be limited according to their performance under their

respective nationally established Component Performance Standards. Similar to the Medicare Volume Performance Standard program, the national performance standard process would include a stop loss to limit reductions in provider payments in a year subsequent to spending in excess of the performance standard.

(g) Evaluation of health plans' performance would take into account differences in the age of plan enrollees. In addition, as data become available the National Health Commission would provide for an exceptions process for health plans that can demonstrate cost increases attributable to "uncontrollable" factors such as unfavorable risk selection among plan enrollees or epidemiological changes.

VI. Quality of Care

(a) Ensuring high quality of health care services must be the highest priority of any health care reform proposal.

(b) Often, the goals of quality and affordability will be consistent. In particular, reforms which promote the primary care model of health care delivery will enhance the quality of care by reducing unnecessary medical and surgical procedures, which can increase patient risk.

(c) In addition, affirmative steps to promote the quality of care must be undertaken. At a minimum,

- health plans should develop risk management/quality assurance programs with required provider participation;
- established outcomes-based clinical practice parameters should be incorporated into health plan quality assurance programs;
- data collected from uniform claims processing systems should be used to profile physician medical practices. Profiling information should be used to educate physicians about their practice patterns and encourage improvements in quality of care.

(d) At no time should the quality of care be sacrificed in the name of cost containment. To protect against this, national and plan-specific performance standard programs must consider evidence of quality concerns in the setting and evaluation of performance standards.

VII. Financing

(a) The Academy's public-private system of ensuring universal access to appropriate health care services should not add to the federal deficit. Every effort should be made to minimize the need for new taxes. However, additional federal expenditures that are necessary should be financed by resource reallocation and modified taxation strategies. The Academy is seeking estimates of the cost of its proposals and will develop more detailed recommendations on appropriate sources of revenues to finance this plan. In the meanwhile, we urge efforts to make taxpayers aware of the realistic cost of health care reform. As taxpayers, family physicians stand ready to pay their fair share for a more equitable and effective health care system.

Conclusion

The Academy believes that any accounting of the costs of this health reform plan should recognize the many offsetting economic benefits to society as a whole as well as to various private and public interests. Among these benefits:

(a) Universal health care coverage will significantly reduce cost shifting due to a heavy burden of uncompensated care, thereby achieving savings for sectors of the economy now bearing these costs.

(b) A generalist-based health care system will achieve savings through improved availability of primary care and through better managed, more appropriate, and more cost effective access to technological specialty services.

(c) Private health insurance reform will promote stability in premiums for small employers and streamline overhead expenses for small group insurers.

(d) Guaranteeing continuous, portable health coverage will eliminate secondary costs to society, including administrative costs of changing coverage and costs to the patient in terms of disruption in care.

(e) Uniform claims and payment policies will create administrative savings to insurers, providers, and premium payers.

(f) Inappropriate increases in health care spending will be limited through the use of volume performance standards.

(g) Medical liability reform will achieve savings through a reduction in costs due to "defensive medicine."

(h) Increases in health care costs to some employers who begin to provide health coverage pursuant to these reforms may be partially offset by savings to some other employers who have been providing health benefits and who have been paying a disproportionate share of the cost of dependents' health care coverage.

Implementation of the foregoing principles will result in a clearly-articulated national health policy with three sources of health insurance coverage — Medicare, employer-provided coverage, and a new publicly sponsored health plan system through which all of those not otherwise covered can be insured. In addition, these principles will promote the development of an adequate supply of properly trained primary care physicians who can ensure delivery of appropriate health care services in a cost efficient manner. Finally, health care reimbursement reforms, insurance reforms, benefit design reforms, and medical liability reforms will create incentives that complement a strengthened health care delivery system built on a primary care model. The American Academy of Family Physicians believes that with these programs in place, every American citizen will be assured of access to a broad range of essential, affordable health care services.

April, 1992

Basic Benefit Package

(Services not specifically listed would not be covered by the basic benefits package)

I. Immediate Access Services

- Prenatal Care
- Well baby and well child care
- Childhood immunizations

NOTE: Immediate access services would be covered under all health plans. No patient cost sharing (i.e., deductible or coinsurance) would be required for these.

II. Preferred Access Services

- Periodic evaluation and screening services, including routine physicals and cancer screening
- All outpatient services provided directly by the patient's Personal Physician

NOTE: Preferred access services would be covered under all health plans. They would not be subject to a deductible, but would be subject to 20 percent coinsurance.

III. Limited Access Services

- Inpatient and outpatient physician services (other than those provided by the patient's Personal Physician)
- Inpatient and outpatient hospital care
- Skilled and intermediate nursing facility care
- Laboratory and radiology services
- Inpatient and outpatient mental health services
- Treatment for substance abuse and addiction
- Inpatient and outpatient prescription drugs
- Medically necessary home health services
- Medically necessary medical equipment
- Routine dental care
- Routine vision care, including eyeglasses
- Routine hearing care, including hearing aids
- Rehabilitation services
- Hospice care

NOTE: Limited access services would be covered under all health plans. They would be subject to a deductible of $250 per person or $500 per family and to coinsurance of 20 percent. An additional 20 percent coinsurance penalty (for a total of 40 percent coinsurance) would be required when these services are rendered by physicians other than the patient's Personal Physician without referral from the Personal Physician. The 20 percent coinsurance penalty would not apply in medical emergencies.

Limits on Scope and Duration of Coverage

Coverage for mental health and substance abuse treatment would be subject to continuing review of medical necessity and appropriateness. Standards for continuing review would be developed by the Secretary of Health and Human Services in consultation with appropriate medical and other professional clinician organizations.

Periodic evaluation and screening services, preventive services, and routine dental, vision and hearing services would be subject to periodicity tables to be developed by the Secretary in consultation with the AAFP and other medical societies.

Catastrophic Protection

All patient cost sharing, except the 20 percent coinsurance penalty on self referral for subspecialty care, would be limited to $1,500 per individual and $3,000 per family per year.

Primary Care and Health

A Cross-National Comparison

Barbara Starfield, MD, MPH

Ten Western industrialized nations were compared on the basis of three characteristics: the extent of their primary health service, their levels of 12 health indicators (eg, infant mortality, life expectancy, and age-adjusted death rates), and the satisfaction of their populations in relation to overall costs of the systems. Information was derived primarily from published sources. Indices were developed to characterize the extent of primary care in each country and the standing of each country relative to the others on the health indicators. There was general concordance for primary care, the health indicators, and the satisfaction-expense ratio in nine of the 10 countries. Ratings for the United States were low on all three measures. West Germany also had low ratings. In contrast, Canada, Sweden, and the Netherlands had generally high ratings for all three measures. The lack of concordance in the ratings in the United Kingdom may be a result of relatively low expenditures for other social services and public education in that country. The findings may add to the debate and deliberations concerning modifications in organization and financing of care that are currently being considered in the United States.

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A PERSISTING sense of crisis in the US health services system is responsible for a new willingness to consider experiences from abroad. Debates focus on the relative advantages of various other systems, with the leading contenders for emulation emerging as the Canadian and West German models.[1]

See also p 2215.

Arguments for and against these and other national systems focus largely on their philosophical underpinnings, especially concerning the appropriate balance between the private sector and government and on the costs associated with the different systems. Little of the debate centers on the value of the systems as reflected by indicators of health that are amenable to medical care.

This article presents the results of an analysis of the characteristics of the systems of primary care in 10 Western industrialized nations and the relationship to the attitudes of the populations toward their health services systems and to levels of health as reflected by 12 indicators.

Since primary care is the place of entry (the "gatekeeper") into health services and the locus of continuing care for most of the health problems that occur in the population, it is an appropriate point of departure for an examination of the relationship between the health system and levels of health.

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METHODS

Ten Western industrialized nations that have comparable data on characteristics of their primary care health systems and health status indicators for the same years were chosen for comparison. Information concerning the characteristics of primary care in the 10 countries was obtained from six major sources.[2-6] Where particular items of information were lacking in these six sources, information was sought from individuals who were from the particular country and who either had access to published data in their country or were experts concerning their country's health services system. Information from the published sources was also confirmed by these individuals or updated where necessary.

Characteristics of primary care were of two types: those related to the overall system and those related to the mode of practice. The former category comprised five characteristics: the type of system (in particular the extent of regulation on place of practice of primary care practitioners); the type of physician who provides primary care (family physician, internist, pediatrician, or specialist); financial access to care (national health insurance sponsored by government, by nongovernmental agencies, or no national health insurance); percentage of active physicians who are specialists; and income of primary care physicians relative to that of specialists.

Six characteristics of primary care were considered to be related to the mode of practice: the extent to which the primary care physician acts as the

Table 1.—Rating Criteria

Criteria for Rating of Health System Characteristics Related to Primary Care
1. **Type of System.**—Regulated primary care or public health centers are considered to be the highest commitment to primary care. Regulated primary care implies that rational policies influence the location of physician practice so that they are distributed throughout the population rather than concentrated in certain geographic areas. Public health centers are also assumed to represent the equitable distribution of physician resources. Intermediate scores connote systems where incentives for equitable distribution are present and moderately effective.
2. **Type of Primary Care Practitioner.**—Generalists (family or general practitioners) are the prototypical primary care physicians because the nature of their training is exclusively devoted to primary care practice. General pediatricians and general internists are considered intermediate primary care practitioners because their training has a major subspecialty focus. Other specialists are not considered primary care physicians because their training is focused on subspecialty issues.
3. **Financial Access to Care.**—Universal government-sponsored national health insurance or a national health entitlement is considered most conducive to access to primary care services. National health insurance sponsored by nongovernmental agencies is considered intermediate because of the absence of uniform benefits. Absence of national health insurance is not considered conducive to access to primary care.
4. **Percentage of Active Physicians Who Are Specialists.**—A value below 50% is considered indicative of an orientation toward primary care. Values of 50% to 75% are considered intermediate, and values above 75% are considered to indicate a specialty-oriented system.
5. **Salary of Primary Care Physicians Relative to Specialists.**—A high ratio (0.9:1 or above) of average salary of primary care physicians to specialty physicians is considered an incentive toward primary care. A low ratio (0.8:1 or less) is considered an incentive toward a specialty-oriented system. Ratios between 0.8 and 0.9 are considered intermediate.
System characteristics not scored for primary care are where care is provided (since there is not evidence that one type of site is better than another), the type of reimbursement of generalists and of specialists (since the impact of type of reimbursement on incentives for primary care practice is unknown), whether or not generalists care for patients in hospitals (since there is little evidence on the impact of this feature of a health services system), and whether or not specialists are restricted to hospitals (since consultations with primary care physicians might be enhanced by limited specialty practice in the community). Even though the assignment of primary care services to a defined geographic area is considered conducive to community orientation and hence potentially pursuant to high level primary care, no points are assigned since community orientation is assessed directly.

Criteria for Rating Practice Characteristics Related to Primary Care
6. **First Contact.**—First contact implies that decisions about the need for specialty services are made after consulting the primary care physician. Requirements for access to specialists via referral from primary care are considered most consistent with the first-contact aspect of primary care. The ability of patients to self-refer to specialists is considered conducive to a specialty-oriented health system. Where there are incentives to reduce direct access to specialists but no requirement for a referral, an intermediate score is assigned.
7. **Longitudinality.**—Longitudinality connotes the extent of relationship with a practitioner or facility over time that is not based on the presence of specific types of diagnoses or health problems. Highest ratings are given where the relationship is based on enrollment with a source of primary care, with the intent that all nonreferred or nondelegated care will be provided by the practitioner. Lowest rates are given where there is not an implicit or explicit relationship over time and intermediate scores are assigned where this relationship exists by default rather than intent.
8. **Comprehensiveness.**—The extent to which a full range of services is either directly provided by the primary care physician or specifically arranged for elsewhere is the measure of comprehensiveness. Highest ratings are given to arrangements for the universal provision of extensive and uniform benefits and for preventive care. Intermediate ratings are given to arrangements for the provision of either extensive benefits or preventive care, or for concerted efforts to improve these for needy segments of the population. Low ratings are given when there is no policy regarding a minimum uniform set of benefits.
9. **Coordination.**—Care is considered coordinated where there are formal guidelines for the transfer of information between primary care physicians and specialists. Where this is present for only certain aspects of care (such as long-term care), intermediate ratings are given. Low ratings reflect the general absence of guidelines for the transfer of information about patients.
10. **Family Centeredness.**—High ratings are given to explicit assumption of responsibility for family-centered care. Only one point is assigned to this characteristic, however, since it is related (although not necessarily identical) to the type of primary care physician.
11. **Community Orientation.**—High ratings are given where practitioners use community data in planning for services or for the identification of problems. Intermediate values are assigned where clinical data derived from analysis of data from the practice are used to identify priorities for care. Low ratings are given when there is little or no attempt to use data to plan or organize services.

point of entry into the system; the extent to which that physician provides continuous (longitudinal) care over time; the comprehensiveness of the care provided; the extent of coordination of services by the primary care physician; the extent to which the physician is "family-centered"; and the community orientation of the physician. All of these characteristics have been considered essential or, at least, important in primary care practice.[5-11]

Possible scores for each of the characteristics ranged from zero (where the level of achievement was not conducive to primary care) to two (where the level of achievement was most conducive to primary care). Intermediate levels of achievement were given a score of one. Table 1 describes the method of scoring. The score for each country was the average of these 11 scores.

A satisfaction-expense ratio was obtained from a study conducted by Blendon et al.[12] These investigators conducted a telephone survey of a random sample of individuals in 10 countries, seven of which are countries in this analysis. Three statements were posed to people who were asked to indicate which came closest to expressing their overall view of the health care system in their country: "On the whole, the health care system works pretty well, and only minor changes are necessary to make it work better"; "There are some good things in our health care system, but fundamental changes are needed to make it work better"; and "Our health care system has so much wrong with it that we need to completely rebuild it." Hellander and Wolfe[13] used the data from that study to calculate a ratio. The numerator of the ratio is the percentage of people who said that their system needed only minor changes divided by the percentage of people who said that the system needed to be completely rebuilt, and the denominator is the per capita cost of the health care system in thousands of dollars.

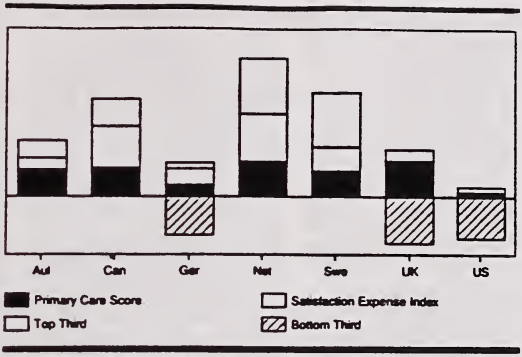
Twelve indicators of health obtained from reliable sources[14-17] were used to compare the countries: neonatal mortality, postneonatal mortality, total infant mortality, age-adjusted death rate, average life expectancy at age 1 year for males and females separately, average life expectancy at age 20 years for males and females separately, average life expectancy at age 65 years for males and females separately, years of potential life lost, and percentage of birth weights below 2500 g. All of these indicators are relatively standard indicators of health. The only one that may require special explanation is years of potential life lost, because it may not be widely known. It reflects that component of mortality occurring before age 65 years that is considered preventable.[18,19] All data on health indicators were from the mid-1980s except for average life expectancy at ages 1 year and 20 years (1980) and low birth weight (1983 or 1984). The data on each indicator were almost always from the same year for every country. Greater detail regarding each indicator is in Starfield.[4]

To summarize the findings for the health indicators, each country was cat-

Table 2 —Health Indicator Status by Country

Countries	Health Indicators*	
	Top Third	Bottom Third
Australia	3	0
Belgium	0	9
Canada	5	0
Denmark	0	3
Finland	5	6
West Germany	1	7
Netherlands	10	0
Sweden	10	0
United Kingdom	0	8
United States	1	7

*These columns present the number of indicators for which the country falls in the top (best) third of the distribution and the number for which it falls in the bottom (worst) third. Sometimes there were three and sometimes four countries in the bottom third, depending on whether or not the countries had very similar values on the indicator. In the case of the top third, there were sometimes only two countries because they had values far better than the middle group which had values very close to each other. Although there were 31 indicators in all (including separate breakdowns by age and sex), comparable information was available for all countries for only 12 of the indicators (excluding death rates from injuries and natural causes by individual child age group, and immunization rates). Similar ratings are obtained, however, when the other indicators are added and used for comparisons among countries for which they were available.



Indicators of health, primary care, and satisfaction and expense. The top third and the bottom third of the distribution contain the number of indicators for which the country was in that third. The ratings for the primary care score were multiplied by 4 to make their ranges comparable with the other two indicators. The satisfaction-expense ratio for the United States was 0.2. Aus indicates Australia; Can, Canada; Ger, West Germany; Net, the Netherlands; Swe, Sweden; and UK, the United Kingdom.

egorized as being in the upper third, middle third, or lower third of the distribution for all 10 countries. Sometimes there were three countries and sometimes four in the bottom third, depending on whether the adjacent countries had very similar values. In the case of the top third, there were sometimes only two countries because they had values far better than the middle group, which had values very close together. For example, the rates of infant mortality ranged from 5.85 to 10.35 per 1000 live births. Finland and Sweden had values of 5.85 and 5.98 per 1000 live births, respectively, whereas the countries in the middle third had values of 7.76, 7.88, 8.19, 8.64, and 8.85 per 1000 live births. The countries in the bottom third had values of 9.55, 9.69 and 10.35 per 1000 live births.

All characteristics reflected the situation existing in the middle to late 1980s.

Additional details concerning the components of the items, the methods of scoring, and the raw data on the scoring of the primary care components and the levels of each of the health indicators can be found in Starfield[9] or obtained from the author.

RESULTS

The primary care scores ranged from 0.2 in the United States to 1.7 in the United Kingdom. Scores for the other countries were as follows: West Germany, 0.5; Belgium, 0.8; Australia, 1.1; Canada and Sweden, 1.2; and the Netherlands, Denmark, and Finland, 1.5.

The satisfaction-expense index ranged from 0.2 in the United States to 9.0 in the Netherlands. Intermediate values were obtained for the United Kingdom and Australia, 2.1; West Germany, 2.9; Sweden, 4.3; and Canada, 7.6. These data were not available for Belgium, Denmark, and Finland.

Table 2 summarizes the position of each country with regard to the health indicators. The United States was in the top third of the distribution for only one indicator—life expectancy at age 65 years for men, in the bottom third for seven of the 12 indicators, and in the middle third for four—life expectancy at ages 1, 20, and 65 years for females and age-adjusted death rate.

West Germany was in the top third for one indicator (neonatal mortality rate), in the bottom third for seven indicators, and in the middle third for four indicator conditions (infant mortality, age-adjusted mortality, years of potential life lost, and the percentage of infants born at low birth weight).

Canada ranked in the top third for five indicators: age-adjusted death rate and life expectancy at ages 1, 20, and 65 years for females and at age 65 years for men. For the remainder of the seven indicators, Canada ranked in the middle third.

The Netherlands and Sweden ranked in the top third for all 12 indicators; only Australia, Canada, the Netherlands, and Sweden had no conditions for which they were in the bottom third of the distribution for the 10 countries.

The United Kingdom had no indicator conditions in the top third of the distribution and eight in the bottom third. The only conditions in the middle third of the distribution were neonatal mortality, life expectancy at age 1 year and 20 years for males, and years of potential life lost.

The Figure summarizes the relationship between the ranking for the primary care score, the satisfaction-expense index, and the health indicators for each of the seven countries for which all three were available. There is a general tendency for the three indicators to relate to each other. That is, where the primary care score is high, so are the satisfaction-expense index and the number of indicator conditions in the top third of the distribution, while the number of indicator conditions in the bottom third of the distribution is low. The major exception was the United Kingdom, which had the highest primary care score but a low satisfaction-expense index, no conditions in the top third of the distribution, and a large number of conditions in the lowest third of the distribution.

COMMENT

There are several potential limitations of these analyses. The findings are from one point in time only, during the middle to late 1980s. The analyses are descriptive and, in part, based on judgments rather than precise measurements of primary care. The data con-

cerning the health indicators assume accuracy of those indicators and the divisions of the indicators into thirds could only be roughly accomplished.

Nevertheless, the data stem from multiple independent sources, which confirm each other. The ranking of the countries on those indicators for which more recent data are available (such as infant mortality) remain the same. The data on health indicators are from reliable published sources, such as the World Health Organization, the Organization for Economic Cooperation and Development, the National Center for Health Statistics, and the Centers for Disease Control.[6-7] The characterization of the countries as high, middle, or low for each of the health indicators was essentially the same when they were characterized by having clearly extreme values on the top or bottom of the distribution or when the countries were ranked and arbitrary cuts were made so that four countries were always in the top third and four in the bottom third of the distribution. That is, the United States, the United Kingdom, and West Germany were low in their standing, whereas the Netherlands, Sweden, and Canada were high in their standing.

The anomalous position of the United Kingdom, with its high primary care score and low ranking on the health indicators, bears comment. The United Kingdom has the lowest per capita spending on health of all of the countries studied. However, per capita spending does not guarantee high performance on the health indicators, as the United States has by far the highest level of spending of all of the countries. Another possible explanation derives from the observation that the United Kingdom and the United States are the only two countries of the 10 studied that are in the lowest third of the distribution both for the percentage of central government expenditures for housing, social security, and welfare, and for education.[8] Although the United Kingdom, the United States, and West Germany are in the top third of the distribution for the percentage of central governmental expenditures for health, there appears to be little relationship between this indicator and levels of health. Access to primary care services may have little impact on health when other social services are underdeveloped and where resources for public education are relatively inadequate.

The findings of this study have implications for the public debate on appropriate models for modifying the financing and organization of health services in the United States. The specialty orientation of the system and underdevelopment of the primary health care system in this country are well recognized.[9] Financial barriers to services in the absence of national health insurance and restrictions in coverage of many existing health insurance policies exacerbate the limitations on access to primary care.

Alternative explanations for the apparent relationship between the level of health indicators and the extent of development of the primary care sector are not readily evident. One commonly expressed view is that the heterogeneity of US population is responsible for its relatively low health levels when compared with the more homogeneous populations of many other industrialized countries. Other analyses have shown that most of the other countries in this study also have substantial minority populations, including the Lapps in Finland, the native American population in Canada, and the foreign workers who have immigrated into many central and northern European countries.[10] At the very least, the findings of this study should indicate the need for consideration of both health levels and the adequacy of the primary care sector when competing systems are debated as possible models for this country.

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Original Contributions

Differences in the Mix of Patients Among Medical Specialties and Systems of Care

Results From the Medical Outcomes Study

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Objective.—To determine differences in the mix of patients among medical specialties and among organizational systems of care.

Study Design.—Cross-sectional analysis of 20 158 adults (≥18 years of age) who visited providers' offices during 9-day screening periods in 1986. Patient and physician information was obtained by self-administered, standardized questionnaires.

Setting.—Offices of 349 physicians practicing family medicine, internal medicine, endocrinology, and cardiology within health maintenance organizations, large multispecialty groups, and solo or small single-specialty group practices in three major US cities.

Outcome Measures.—Demographic characteristics, prevalence of chronic disease, disease-specific severity of illness, and functional status and well-being.

Results.—Among patients with selected physician-reported chronic illnesses (diabetes, hypertension, recent myocardial infarction, or congestive heart failure), increasing levels of severity were associated with decreasing levels of functional status and well-being and with increased hospitalizations, more physician visits, and higher numbers of prescription drugs. Compared with patients of general internists, patients of cardiologists were older (56 vs 47 years, $P<.01$), had worse functional status and well-being scores ($P<.01$), and carried more chronic diagnoses (mean 1.32 vs 1.02, $P<.01$); patients of family practitioners were younger (40 vs 47 years, $P<.01$) and more functional ($P<.01$), carried fewer chronic diagnoses (0.70 vs 1.02, $P<.01$), and (among diabetic patients only) had lower disease-specific severity scores (2.06 vs 2.30 on a five-point scale, $P<.01$). Compared with patients in health maintenance organizations, patients visiting solo practitioners under fee-for-service payment were older (50 vs 45 years, $P<.01$) and sicker (had worse physical functioning) and had a higher mean number of chronic diagnoses (1.10 vs 0.93, $P<.01$).

Conclusion.—Patient mix is related to utilization and differs significantly across medical specialties and systems of care. These differences must be taken into account when interpreting variations in utilization and outcomes across specialties and systems, and when considering alternative policies for payment.

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IMPORTANT choices currently facing health care policymakers depend on answers to several critical questions. What form of specialty training is the best preparation for the primary care or gatekeeper role? What system of health care provision yields the best care at an affordable cost? Does the way in which physicians respond to different payment incentives affect patients' health? Although a number of studies have attempted to address these questions,[1-3] most have been limited by inadequate control for the differences in the mix of patients treated by different specialties and systems. Because the mix of patients in a practice can affect utilization[4-6] and outcomes, comparing practices without randomizing patients or controlling for important confounders can severely bias the results.

See also pp 1624 and 1665.

The Medical Outcomes Study (MOS) is an observational study having two major purposes: first, to compare variations in patient outcomes with differences in the physicians' specialty, the system from which the patient receives care, the intensity of resource use, and the clinicians' technical and interpersonal styles; and second, to develop practical tools for monitoring patient outcomes and their determinants in routine practice. The MOS examines variations in services and outcomes among patients with chronic conditions that commonly affect adults. Both cross-sectional and longitudinal data were collected. Key elements of the MOS patient mix adjustment strategy include (1) sampling by chronic tracer condition, (2) assessment of the severity of tracer and comorbid conditions with new measures developed for office practice, and (3) use of statistical methods to control for observed differences in patient mix in the interpretation of results.[7]

In a companion article in this issue of *JAMA*,[8] we report the effects of physician specialty, organization of practice, and payment system on multiple aspects of health care utilization. In this report, we lay the groundwork for that analysis by measuring differences in patient mix across specialties and systems of care.

METHODS

Design Overview

The MOS sampled physicians and patients treated in different systems of care in three geographic sites (Boston, Mass, Chicago, Ill, and Los Angeles, Calif).[10] Data describing the patients, the clinicians, treatment processes, utilization of resources, and health outcomes were gathered from multiple sources including clinician reports, patient reports, and independent clinical examinations. A subset of patients was followed up longitudinally. This article focuses on the cross-sectional study and only on nonpsychiatric physicians. Details on selection of sites, physicians, and patients are reported elsewhere[10,11] and are summarized below.

Sampling

A four-step process was used to select geographic sites, systems of care, clinicians, and patients.[12] First, three communities—Boston, Chicago, and Los Angeles—were selected. They represented three of the four census regions and met the following criteria: (1) presence of a large health maintenance organization (HMO) in existence for 3 years and with at least 100 000 enrollees, (2) presence of numerous multispecialty groups having at least 10 physicians each, and (3) willingness of groups and physicians to participate in the study.

Second, one large HMO, several multispecialty groups, and physicians practicing within solo or single-specialty small group practices (nine or fewer physicians) were selected within each city to represent the organizational forms of practice expected to predominate during the next decade.

Third, clinicians practicing within each of the different systems of care in the three MOS cities were asked to participate in the study. To be eligible, physicians were required to be board certified or board eligible in family medicine, internal medicine, cardiology, or endocrinology and to be between 31 and 55 years of age. Nurse practitioners (all of whom worked in HMOs) were included in the calculation of overall response rates and in the analysis of patient mix by system, but not patient mix by specialty. Studies of the psychiatrists and psychologists are reported elsewhere.[13,14]

Altogether, 284 HMO and multispecialty group practitioners met the eligibility criteria; 225 (79%) agreed to participate and permitted their patients to be screened for entry into the MOS. Of 1774 potentially eligible solo and small single-specialty group practitioners whose names were obtained from the American Medical Association Masterfile and the American Academy of Family Practice, 1525 (86%) expressed initial interest in the study and agreed to provide further information; 894 passed all the eligibility screens. Of these, 513 were selected to fill specialty and geographic sampling quotas, and 298 (58%) agreed to enroll patients in the study.

The final provider sample for this analysis included 362 providers (349 nonpsychiatric physicians and 13 nurse practitioners); 114 (31%) were in HMOs, 76 (21%) in large multispecialty groups, and 172 (48%) in solo or small single-specialty group practices. Among 349 physicians, 56% practiced general internal medicine (n = 194), 26% family medicine (n = 91), 12% cardiology (n = 40), and 7% endocrinology (n = 24). The mean age of the practitioners varied by specialty ($P<.0001$), with a range from 37.4 years for family practice to 42.6 years for cardiology. There were no statistically significant differences among specialties for gender and race. The non-HMO physicians differed in the proportion of prepaid patients in their practices: family practice had 60%, general medicine 45%, endocrinology 28%, and cardiology 16%. Physician participants in the MOS were similar to nonparticipants in terms of age, gender, foreign training, specialty, and percentage of fee-for-service patients. However, clinicians who had large patient loads (>150 visits per week) or very small patient loads were less likely to participate.

The fourth step was to sample English-speaking adults (>18 years) among patients visiting the study clinicians during 9-day screening periods from February through October 1986. Not counting patients visiting mental health providers but including those who saw nurse practitioners, 28 257 patients were approached and 20 223 (71%) agreed to participate; of these, 65 were patients of physicians who later left the study, for a final analytic sample size of 20 158. The proportion of patients refusing to participate because of illness was 6% and did not vary by specialty.

Within multispecialty group practices and solo and single-specialty group practices, patients were insured on either a fee-for-service or a prepaid basis. Thus, patients were classified as belonging to one of five systems of care: HMO, multispecialty group—prepaid, multispecialty group—fee-for-service, solo practice or small single-specialty group—prepaid, or solo practice or small single-specialty group—fee-for-service. The five systems of care are more fully described in the companion paper by Greenfield et al.[11] Forty-five percent of multispecialty group patients were prepaid, vs 13% of solo practice/single-specialty group. There were more women physicians in HMOs (40%) than in the multispecialty groups (19%) or the solo practices (13%). There were no age or race differences among the physicians in the various systems of care.

Data Collection

Data reported in this article were obtained from both patients and physicians. Patients agreeing to participate completed a screening form while visiting the office of study physicians. To reduce respondent burden, every other patient in each office was assigned to one of two alternate screening forms, each requesting both unique and common information. Half of the patients completed the health status evaluation. Because a large number of patients were randomly assigned to each form, it is unlikely that the results on half of the patients varied substantially from the entire patient pool. For 96% of the patients, physicians completed postvisit encounter forms that included questions on prescribed medications, tests ordered, and characteristics of the patients' chronic conditions.

Patient Mix: Sociodemography, Disease Prevalence, Disease Severity, Functional Status, and Well-being

While various terms are used to denote the severity and complexity of illness,[15,16] we use "patient mix" as the most comprehensive term for those characteristics that could affect the interpretation of specialty and system differences in intensity of resource use and patient outcomes. We consider patient mix to consist of four components: sociodemographic characteristics, disease prevalence, disease-specific severity as measured using conventional biomedical parameters, and functional status and well-being.

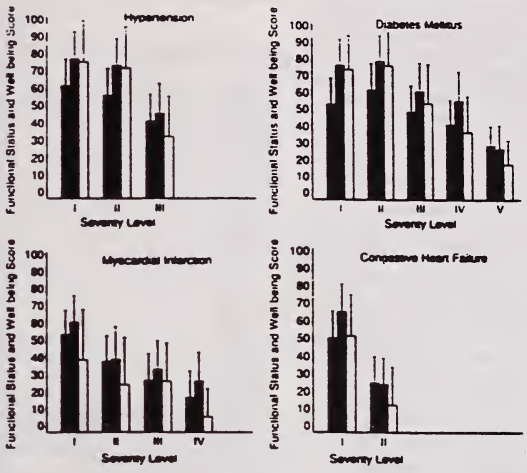
The comparisons of patient mix across specialty and system were approached in four ways. First, the sociodemographic characteristics (age, gender, race, education, household income, marital status, family size, and employment) of patients in the different practices were compared. Second, information was obtained directly from patients on their functional status and well-being (including general health perceptions, physical functioning, and role functioning), using the 20-item MOS short-form health status measures as previously described.[17] Third, the prevalence of the four medical MOS tracer conditions (hypertension, diabetes, recent myocardial infarction, and congestive heart failure) was estimated using information from the physician-completed encounter form. Patient-derived information was used to determine the prevalence of chronic

conditions other than the MOS tracer conditions and to verify that all specialists were equally likely to be aware of, and report, each disease. Fourth, for each of the four MOS tracer conditions, disease-specific severity was measured using information from the physicians. The formation of these newly developed disease-specific severity measures will be described below.

Disease-Specific Severity Measures.—Because the development of disease-specific clinical severity measures for office practice has been limited and defined in terms of resource use,[7] new measures were developed for the MOS based on prior research[8,9,10,11] and on the recommendations of experts forming the MOS advisory committee.[12] We conceptualized severity such that patients with more "severe" disease were expected to have poorer health (operationalized as diminished functional status and well-being) over the next 2 to 4 years. The ordinal measures were developed independently of any knowledge of the patients' functional status and well-being and were tested empirically against these functional status and well-being measures collected concurrently in the cross-sectional study. For diabetes, we asked physicians whether their patients had cardiac, renal, ophthalmologic, or foot complications of diabetes. Based on these variables and on the duration of diabetes, we established five mutually exclusive disease-specific severity categories expected to have an ordinal relationship with functional status and well-being. Hypertension severity was based on level of blood pressure and the presence of congestive heart failure. Recent myocardial infarction severity was dependent on the presence of ongoing congestive heart failure, angina pectoris, and multiple premature ventricular contractions. Congestive heart failure severity depended on the presence or absence of orthopnea or dyspnea on one block of exertion. To avoid mixing intrinsic severity with physician treatment style, in no case were treatment variables (such as insulin use or the number of antihypertensive medications) used in the classification scheme. Further details are given in the Appendix.

Functional Status and Well-being.—The (20-item) MOS short-form patient health survey[13] was used to construct health status indicators for general health perceptions, physical function, role function, social function, bodily pain, and mental health.[11,13] Scores for three representative scales (physical functioning, role functioning, and general health perceptions) are reported herein. Scores for these scales in this population of patients with MOS tracer conditions were scaled from 0 to 100 and ranged from scores indicating severe loss of functioning (20 to 30) to scores found among patients free of chronic disease (90 to 100). In this study population, a nine-point difference in physical functioning is equivalent to the effect of having arthritis, a 13-point difference in general health perceptions is equivalent to the effect of having diabetes or congestive heart failure, and nine- and 16-point differences in role functioning are equivalent to the effect of having diabetes or angina, respectively.[11]

Utilization Rates.—Hospitalization rates, physician office visits, number of medications prescribed, and the percentage of patients receiving one or more selected diagnostic tests were measured as described in the companion article on utilization.[14]



The relationship of disease-specific severity to general health perceptions (lightly shaded bars), physical functioning (darkly shaded bars), and role functioning (unshaded bars) for hypertension, diabetes mellitus, myocardial infarction, and congestive heart failure, adjusted for demographic characteristics. Increasing clinical severity levels are shown on the horizontal axis and the health status scores on the vertical axis, with a higher score meaning better health. Length of error bar indicates 0.5 SD. With some exceptions, the severity levels included at least 50 patients and most had well over 100. Only these had fewer than 50: for myocardial infarction, levels II, III, and IV; and for diabetes mellitus, level V.

Data Analysis

Statistical Modeling.—Statistical models were constructed to estimate the following associations: (1) functional status and well-being by clinical severity of illness, (2) measures of patient mix by specialty, and (3) measures of patient mix by system of care. Among patients with at least one tracer condition, multivariate linear regression was used to estimate mean functional status and well-being scores at each level of clinical severity after adjusting for patient demographic characteristics (age, sex, ethnicity, education, income, marital status, family size, and employment.) The mix of patients in each specialty was estimated with multivariate linear regression and logistic regression[15] after controlling for city and system of care. The mix of patients in each system of care was modeled similarly, except that adjustment was made for city only. Statistical significance testing was for overall differences between groups, using an F test. Where pairwise differences are cited, the P values have been adjusted for multiple comparisons using the Bonferroni method.[16]

Management of Missing Data.—A patient was excluded from the analysis of a particular measure of patient mix if data on that variable were missing. Sensitivity analyses showed that the results were not

materially affected by missing data. Sample sizes are reported for each analysis.

Cluster Effects: Correction for Correlations Among Patients of Providers.—Because a series of patients was selected from each provider's office practice, characteristics of each provider's patients would tend to be positively correlated. Failure to correct for this correlation would result in larger (more "significant") inference statistics and lower P values than the data warrant.[23,24] Therefore, all estimates were corrected for lack of independence among the patients of the same provider.

Accounting for Seasonality.—Because screening occurred over a 7-month period, we examined the effect of the time of sampling on mean number of chronic diseases per patient in different specialties and systems. Since a preponderance of wintertime visits might be for upper respiratory tract infections, failing to make the indicated adjustments might make HMO patients (who were sampled earlier in the year) appear less chronically ill than they really are. Adjusting for season did not affect the results for specialty. Adjusting for season resulted in small changes for system, tending to reduce the differences.

Weighting for Unequal Sampling.—All results have been weighted to correct for the effects of unequal sampling probabilities and thereby better represent the original population of physicians and patients from which the sample was selected. The weighting strategy, which is related to that used in conventional stratified designs, addresses the following features of the MOS sampling design: (1) stratified sampling of specialties and systems within each city, (2) sampling of fixed numbers of patients in unequal-sized practices, and (3) sampling of patients who actually visited providers but making inferences about all potential users of the different specialists and systems. Further technical information on weighting is found in the study by Rogers et al.[22]

RESULTS

Validity of the Measures: Relationship Between Functional Status and Disease Severity

Among 2883 patients with hypertension, diabetes, myocardial infarction, or congestive heart failure and after adjustment for demographic characteristics, scores for general health perceptions, physical functioning, and role functioning declined with increasing clinical severity ($P<.0001$ by F test) (Figure). For example, in patients with hypertension (and after adjusting for age and other demographic characteristics), physical function scores ranged from the high 70s in the milder categories to 48 in the most severe group. Mean adjusted physical function scores for diabetic patients similarly ranged from 79 to 23. The SDs around the means for functional status and well-being were large within severity categories, ranging from 26 to 44, suggesting that much of functional status is not explained by disease severity.

Table 1.—Health Care Utilization by Patient Mix*

Measure of Patient Mix	Measure of Health Care Utilization: Hospitalization Past 3 mo, %	Office Visits Past Year, Mean per Patient	No. of Prescriptions, Mean per Patient	Any Test Received, %
Age				
Youngest	4.0	3.86	0.9	43
Middle 50%	4.8	4.30	1.4	47
Oldest 25%	10.5	5.62	2.4	46
Health perceptions				
Excellent	2.7	3.09	0.8	45
Very good	3.5	3.84	1.1	44
Good	5.9	4.88	1.7	45
Fair	14.5	6.55	2.6	48
Poor	25.8	8.11	3.1	51
No. of chronic conditions†				
0	‡	3.62	0.8	45
1		4.98	1.4	45
2		5.71	2.2	45
3		6.56	3.1	48
Disease severity category				
I	7.3	6.16	2.6	64
II	11.4	5.83	2.5	56
III	11.4	6.85	2.7	74
IV	21.7	7.08	4.0	62
V	29.5	7.52	4.4	56

*Results are weighted for statistically sampling probabilities.
†Including hypertension, diabetes, recent myocardial infarction, congestive heart failure, arthritis, chronic lung problems, gastrointestinal problems, back problems, neurological disease, kidney disease, other heart disease, cancer, or "other major medical problems."
‡Information on both number of chronic conditions and hospitalizations was not available because of the qualitative design of the screening questionnaire.

Health Care Resource Utilization by Patient Mix

On average, patients who were older had lower general health perceptions, and had more chronic conditions made more office visits and took more medications (Table 1). Older patients and those with lower health perceptions were more likely to have been hospitalized in the past 3 months. Among patients with diabetes, those in the worst clinical severity category (level V) were four times as likely to have been hospitalized, made 20% more visits, and took 70% more medications than those in the best severity category (level I). The probability of receiving a diagnostic test during an office visit during the past year was not related to patient mix.

Patient Mix by Specialty

The mean age of adult patients (≥18 years of age) in the practices of the four specialties considered in the analysis ranged from 40 years (family practice) to 56 years (cardiology) (Table 2). General internal medicine patients were about 7 years older than family practice patients ($P<.0001$) and were twice as likely to be at least 65 years old (20% vs 10%, $P<.0001$) (data not shown in tabular form). Patients of endocrinologists were more likely to be female; patients of cardiologists were more likely to be male and white.

Patients under the care of different specialists also displayed sizable differences in mean functional status and well-being scores (Table 2). Adult patients of family physicians scored almost six points higher than patients of general internists on scales measuring general health perceptions, physical functioning, and role functioning, and patients of cardiologists scored four to 10 points lower than patients of general internists. Endocrinology and internal medicine patients had comparable scores. The specialty differences in functioning and well-being were accounted for completely by patients having at least one chronic medical condition (any MOS tracer, other heart disease, gastrointestinal disease, cancer, arthritis, chronic lung disease, kidney disease, neurological disease, chronic back pain, or "other chronic condition") (data not shown). Although similar patterns across specialties were dis-

Table 2.—Differences in Patient Mix by Specialty*

Indicator of Patient Mix	Specialty				P
	Family Practice (n = 6438)	General Internal Medicine (n = 11 308)	Endocrinology (n = 1122)	Cardiology (n = 1425)	
Demographics					
Mean age, y	40.0	46.9	44.2	55.5	<.0001
Male, %	42.2	42.3	34.4	52.6	<.0001
Nonwhite, %	18.4	23.2	22.2	13.2	.01
Education, y	13.6	13.5	14.0	13.1	.01
Insured, %	24 986	24 746	27 847	25 860	.14
Married, %	58.2	59.1	61.9	66.2	.02
Family size	2.46	2.37	2.42	2.25	.04
Functional status and well-being (0-100 scale)					
Health perceptions	72.8	67.0	67.9	63.0	<.0001
Physical functioning	86.7	83.1	85.7	75.3	<.0001
Role functioning	84.9	78.5	79.2	66.2	<.0001
Disease prevalence and severity†					
Chronic diseases, No. per patient	0.70	1.02	1.05	1.32	<.0001
Any chronic disease, %	51.0	61.1	58.7	72.9	<.0001
Hypertension, %	17.3	29.8	21.4	37.3	<.0001
Severity, mean	1.16	1.18	1.18	1.27	Not significant
Diabetes, %	3.4	6.9	21.9	6.9	<.0001
Severity, mean	2.06	2.30	2.24	3.03	<.0001
Myocardial infarction, %	0.3	1.1	1.7	7.2	<.0001
Severity, mean	2.11	2.19	2.40	1.86	NS
Congestive heart failure, %	0.6	2.0	1.8	6.9	<.0001
Severity, mean	1.80	1.80	1.80	1.55	NS

*Sample of 19 283 patients of medical practitioners who completed screening questionnaires, except for congestive heart failure severity, where sample size is limited to patients completing form B of the extended cohort that included patient-reported symptoms. Results were adjusted for city, system of care, and occasion in which sampling occurred. These data apply to the systems and sites studied in the Medical Outcomes Study. However, variations in results between sites suggests that they should not be generalized beyond the Medical Outcomes Study sites.

†Including hypertension, diabetes, recent myocardial infarction, congestive heart failure, arthritis, chronic lung problems, gastrointestinal problems, back problems, neurological disease, kidney disease, other heart disease, cancer, or "other major medical problems." The range of tracer severity scale scores is as follows: hypertension, 1 to 3; diabetes, 1 to 5; myocardial infarction, 1 to 4; and congestive heart failure, 1 to 2.

played in both fee-for-service and prepaid settings, the observed differences were most consistent in the fee-for-service sector (data not shown).

The mean number of chronic conditions per patient was greatest among patients of cardiologists (1.32), followed by patients of endocrinologists (1.05), general internists (1.02), and family physicians (0.70) (Table 2). The differences between internal medicine and both family practice and cardiology were highly statistically significant ($P<.0001$) and are reflected in the relative percentages of patients with "any chronic condition" (Table 2). After weighting and adjustment for city and system of care, from 27% to 49% of the patients across specialties had no chronic condition, indicating that a large proportion of patients in these practices saw their physician for general physical examinations, acute problems, or conditions not captured by the MOS list, and not considered by the patient to fall under the heading of "other chronic condition."

The prevalence of each of the four MOS tracer conditions was lower in family practice than in general internal medicine, cardiology, or endocrinology (Table 2). As could be expected, cardiologists had more patients with hypertension and heart disease, and endocrinologists had more patients with diabetes. There were significant differences in diabetes severity among specialties, with cardiologists seeing the most severely ill patients. Diabetic patients under the care of endocrinologists were almost twice as likely as those under the care of general internists to be taking insulin (61% vs 34%, $P<.001$, data not shown).

Patient Mix by System

Table 3 displays sociodemographic characteristics, functional status and well-being scores, and disease prevalence and severity for patients in the five systems of care. Compared with patients in other systems, those insured under a fee-for-service arrangement and visiting solo or small-group single-specialty practices were significantly older, less likely to be nonwhite, and somewhat less functional and had more chronic diseases (Table 3). Multispecialty group–prepaid patients were most likely to be nonwhite and least likely to have a chronic condition and had the highest scores on the health perceptions and physical functioning scales (Table 3). The severity of the tracer conditions was not significantly different across the systems. In summary, solo practices/single-specialty group–fee-for-service patients appeared to carry the heaviest burden of illness and prepaid patients (especially multispecialty group–prepaid) the least.

COMMENT

These MOS results indicate that patient mix (sociodemographics, disease prevalence, disease-specific severity, and functional status and well-being) differs according to both physician specialty and system of care. In addition, the results confirm previously reported associations between patient mix and health care utilization.[7,8] Thus, careful measurement of patient mix is critical to interpreting both utilization and outcome data for different types of practices.

In addition, the information provided by patients on how well they performed in usual life activities and their overall assessment of their health agreed, on average, with physician-reported severity of disease as conventionally measured in medical practice. Average health scores increased linearly with decreasing severity, were consistent across several diseases and measures of functioning, and spanned a wide range of functional status and disease severity scores. The data support the validity of both the functional status scales designed for the MOS and the disease severity measures developed separately for this study and indicate that both types of measures contribute unique information. Explaining the residual variation in functional status at a given level of disease severity is an important topic for additional research.

There were distinct differences in patient characteristics in the practices of family physicians, general internists, endocrinologists, and cardiologists. In general, the patients of practitioners of general internal medicine and endocrinology were similar; cardiology patients had greater illness burden than both family medicine patients had less. The severity of diabetes in the practices of endocrinologists was not substantially different from that of the diabetics in the practices of general internists, except that a much higher proportion of the former were taking insulin.

The sorting system for patients into different practices appears to have a certain rationale. By and large, family physicians are caring for a younger cohort of patients having less chronic disease; they have practices in which their preference for families and prevention can be emphasized, and their younger

Table 3 — Differences in Patient Mix by System of Care*

Indicator of Patient Mix	System of Care†					
	HMO (n = 7561)	MSG-PP (n = 1975)	Solo/SSG-PP (n = 12851)	MSG-FFS (n = 2469)	Solo-FFS (n = 6838)	P
Demographics						
Mean age, y	45.0	38.6	42.4	44.8	48.2	<.0001
>65 y, %	16.0	5.0	13.2	17.2	24.6	<.0001
Male, %	38.3	42.2	44.8	43.8	43.4	Not significant
Nonwhite, %	30.2	33.2	17.6	28.2	10.1	<.0001
Education, y	13.6	13.6	13.9	13.1	13.6	.001
Income, $	23 274	23 785	25 713	22 813	27 288	<.001
Married, %	58.6	57.5	56.4	51.7	62.3	<.001
Family size	2.38	2.55	2.35	2.33	2.35	.003
Functional status and well-being (0-100 scale)						
Health perceptions	68.2	71.1	68.0	67.1	67.6	.02
Physical functioning	84.7	87.8	84.2	83.2	83.0	.002
Role functioning	81.2	81.6	79.4	78.3	77.9	NS
Disease prevalence and severity‡						
Chronic illness, No. per patient	0.83	0.89	0.81	0.83	1.10	<.0001
Any chronic disease, %	38.5	40.7	34.9	37.1	42.7	<.001
Hypertension, %	23.4	15.6	24.3	25.3	32.3	<.0001
Severity, mean	1.17	1.18	1.22	1.19	1.19	NS
Diabetes, %	7.4	3.4	5.7	6.5	7.5	.03
Severity, mean	2.28	2.15	2.20	2.21	2.40	NS
Myocardial infarction, %	0.9	0.3	1.0	1.3	2.2	<.003
Severity, mean	2.07	1.83	2.44	2.04	2.86	NS
Congestive heart failure, %	1.5	0.6	2.1	2.0	3.1	<.001
Severity, mean	1.50	1.57	1.47	1.85	1.89	NS

*Samples of 20 156 patients of physicians and nurse practitioners who completed screening questionnaires, except for congestive heart failure (severity, where sample size is limited to patients completing Form 8 of the examiner (which included patient-reported symptoms). Sixty-two patients visited physicians who later withdrew from the study. Results were adjusted for city, system of care, and season in which sampling occurred. These data apply to the systems and cities studied in the Medical Outcomes Study. However, variation in results between cities suggests that the effect should not be generalized beyond the Medical Outcomes Study cities.

†HMO indicates health maintenance organization; MSG-PP, multispecialty group—prepaid; Solo/SSG-PP, solo practice/single-specialty group—prepaid; MSG-FFS, multispecialty group—fee-for-service; and Solo-FFS, solo practice—fee-for-service.

‡Included hypertension, diabetes, recent myocardial infarction, congestive heart failure, arthritis, chronic lung problems, gastrointestinal problems, heart problems, neurological disease, kidney disease, other heart disease, cancer, or "other major medical problems." The range of mean severity scale scores is as follows: hypertension, 1 to 3; diabetes, 1 to 5; myocardial infarction, 1 to 4; and congestive heart failure, 1 to 2.

age is reflected in the relative youth of their patients. Cardiologists are concentrating on an older age group having higher prevalences of diseases with cardiovascular complications for which cardiologists have been trained. Endocrinologists, as expected from the relatively younger age distribution of hormonal derangements, care for a younger age group with a higher proportion of women and a high proportion of diabetics who take insulin. The general internists are somewhere between the family physicians on the one side and the two subspecialty groups on the other with respect to the prevalence of chronic disease and degree of functional impairment. That such a sorting system exists does not speak to its value.

Patient mix also varied across the five systems of care. The two fee-for-service groups (solo practice/single-specialty group—fee-for-service and multispecialty group—fee-for-service) had patients who were generally older, were more likely to be white, had more chronic diseases, and had lower functional status and well-being scores. Younger, healthier, and better functioning patients, on average, selected HMOs and other prepaid systems.

Several limitations of this study must be acknowledged. First, the sampling strategy could have produced some of the observed specialty and system differences. However, we sampled physicians from a relatively homogenous population and used similar sampling procedures for all specialties. Likewise, all patients were sampled using similar procedures, and few patients in any specialty or system declined to participate because they felt too sick. Also, by weighting according to the timing of the patient's last visit, we corrected for the tendency of one kind of practice to see patients more frequently than another.

Second, the data in this study were derived from physician and patient reports and, as such, are subject to inaccuracies in recollection and reporting. However, all patients spoke English, and we have no reason to suspect differential recall across specialties or systems. The observed prevalence of the physician-reported conditions could have varied because of differential propensity to record diagnoses by specialty, but this probably applies only to those patients whose manifestations of disease were subtle.

Third, the three MOS cities are somewhat unique in the landscape of the American health care system: each is large, cosmopolitan, and influenced by one or more major academic medical centers. The results should probably not be generalized beyond the three cities studied.

We took care to construct disease-specific severity measures that were not confounded by treatment variables such as number of antihypertensive or cardiac medications or use of insulin injections. When treatment variables were included in the severity scales, differences in severity of illness between internal medicine and family practice were larger than reported herein.[28] The decision to exclude treatment variables from the severity measures was difficult because for some conditions (eg, hypertension), intensity of treatment may be a better indicator of complexity than degree of physiological derangement (ie, blood pressure measure at any given visit). However, avoidance of distortion by physician practice style is important to patient mix determinations.

With these caveats in mind, the observed differences in patient mix among specialties and systems may have developed in three ways. First, older, sicker patients may have been attracted to particular specialists (ie, internists or cardiologists), organizational structures (solo or small single-specialty practices), or payment schemes (fee-for-service). In particular, older, sicker patients may have perceived capitated payment plans to offer a too limited selection of physicians, access to highly specialized physicians and technology, and access to hospitalization for their needs. The characteristically American preference for freedom of choice may be especially strong among patients with chronic diseases or patients who believe they may need medical services in the near future.[29] Under such circumstances, patients might be prepared to sacrifice financial savings to gain increased latitude of choice.

Second, sicker patients and those who were older may have been diverted to particular kinds of practices by a system of barriers and incentives. Subspecialists and physicians practicing in noncapitated systems may be perceived by patients as better prepared to care for more complicated patients, or to provide services or amenities that result in higher levels of patient satisfaction. Pa-

tients might also be referred differentially for these reasons.

Finally, poor quality of care could have led to worse health among patients in certain kinds of practices. However, this seems unlikely since it would not account for differences in age and prevalence of chronic disease. Quality of care and patient outcomes will be assessed in the longitudinal part of the study.

These results have three principal implications. First, it is clear that adjusting for patient mix differences is essential for valid interpretation of utilization and outcome data. Second, the definition of patient mix must be comprehensive, including not only sociodemographic characteristics, disease prevalence, and disease-specific severity, but also functional status and well-being. That the measures of functional status and well-being were related to disease-specific severity but did not correlate perfectly indicates that each kind of measure provides meaningful clinical information not completely conveyed by the other. Third, regardless of the reasons, the mix of patients in different specialties and systems of care does vary, and these variations must be addressed by policies concerned with physician payment, medical education and training, and provider choice of practice setting.

APPENDIX: FORMATION OF DISEASE-SPECIFIC SEVERITY SCALES

Hypertension

Presence.—Patients were classified as having hypertension if their physician reported the diagnosis or found the diastolic blood pressure to be greater than or equal to 90 mm Hg.

Severity.—There were three levels of severity for hypertension.

Category I.—Patients with no congestive heart failure and diastolic blood pressure below 100 mm Hg.

Category II.—Those without congestive heart failure but with physician-reported diastolic blood pressure greater than or equal to 100 mm Hg.

Category III.—Those with hypertension and congestive heart failure.

Diabetes

Presence.—Physician-reported diagnosis.

Severity.—Based on disease duration and complications of the heart, kidney, eye, and foot.

Category I.—Patients without physician-reported complications and with disease duration less than 10 years.

Category II.—Those without complications but with disease exceeding 10 years in duration.

Category III.—Those with eye or foot disease (but not heart or kidney disease).

Category IV.—Those with diabetic heart or kidney disease.

Category V.—Those with physician-reported diabetic heart disease and kidney disease.

Recent Myocardial Infarction

Presence.—Physician-reported myocardial infarction within the past year.

Severity.—Based on the presence of physician-reported congestive heart failure, angina pectoris, and premature ventricular contractions.

Category I.—Patients free of congestive heart failure, angina, and premature ventricular contractions.

Category II.—Those with angina only or premature ventricular contractions only.

Category III.—Those with either congestive heart failure alone or angina plus three consecutive premature ventricular contractions.

Category IV.—Those with congestive failure, angina, and three or more premature ventricular contractions in a row since the myocardial infarction.

Congestive Heart Failure

Presence.—Physician-reported diagnosis.

Severity.—Based on patient-reported dyspnea (and thus available for only half of the sample).

Category I.—Patients without dyspnea on one-block exertion or while lying flat.

Category II.—Those with dyspnea under these circumstances.

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Variations in Resource Utilization Among Medical Specialties and Systems of Care

Results From the Medical Outcomes Study

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Objective.—To examine whether specialty and system of care exert independent effects on resource utilization.

Study Design.—Cross-sectional analysis of just over 20 000 patients (≥18 years of age) who visited providers' offices during 9-day periods in 1986. Patient- and physician-provided information was obtained by self-administered questionnaires.

Setting.—Offices of 349 physicians practicing family medicine, internal medicine, endocrinology, and cardiology within health maintenance organizations, large multispecialty groups, and solo practices or small single-specialty group practices in three major US cities.

Outcome Measures.—Indicators of the intensity of resource utilization were examined among four medical specialties (family practice, general internal medicine, cardiology, and endocrinology) and five systems of care (health maintenance organization, multispecialty group–fee-for-service, multispecialty group–prepaid; solo practice and single-specialty group–fee-for-service, and solo practice and single-specialty group–prepaid) before and after controlling for the mix of patients seen in these offices. The indicators of resource utilization were hospitalizations, annual office visits, prescription drugs, and common tests and procedures, with rates estimated on both a per-visit and per-year basis.

Results.—Variation in patient mix was a major determinant of the large variations in resource use. However, increased utilization was also independently related to specialty (cardiology and endocrinology), fee-for-service payment plan, and solo and single-specialty group practice arrangements. After adjusting for patient mix, solo practice/single-specialty groups–fee-for-service had 41% more hospitalizations than health maintenance organizations. General internists had utilization rates somewhat greater than family physicians on some indicators.

Conclusion.—Although variations in patient mix should be a major determinant of variations in resource use, the independent effects of specialty training, payment system, and practice organization on utilization rates need further explication. The 2- and 4-year outcomes now being analyzed will provide information critical to interpretation of the variations reported herein.

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DESPITE efforts at containment, the costs of health care in the United States continue to rise faster than prices in other parts of the economy.[1] Research spanning several decades has uncovered many factors that contribute to these high costs, including patient sociodemographics, disease severity, provider specialty training and professional socialization, the organization of medical care services, the method of physician payment, and uncertainty surrounding medical decision making. If we can identify and measure those factors that contribute little to better patient outcomes, then cost-containment efforts can be targeted effectively to achieve the most health care benefit at the lowest cost.

See also pp 1617 and 1685.

Two major problems have plagued past studies of health care utilization. One is the difficulty in isolating each of these factors because they are not independent of each other. Certain forms of medical practice may have specialists working in different ways than they would in other forms of care. Certain systems of care may attract different kinds of patients. Certain kinds of provider organizations may receive income through multiple forms of payment, including, as a recent development, the incorporation of capitation patients into solo or single-specialty group practices.

A second major problem is the difficulty in taking into account "selection bias."[2,3] This term refers to variables, often not adequately measured, that are associated with both utilization and patient health status. Selection bias can lead to faulty comparisons of patients in different systems and of specialists who have different mixes of patients. Fair comparisons can only be made, optimally, by randomizing patients or, alternatively, by controlling for disease-specific severity, health status, and sociodemographic and geographic factors that are potentially related to utilization.

For these reasons, it is valuable to examine all of these factors simultaneously in multiple settings to determine the unique contribution of each to utilization. The Medical Outcomes Study (MOS) facilitates estimation of utilization variances because of (1) its use of a comprehensive set of variables to control for selection bias and patient mix, (2) its separation of the effects of the organization of practice from form of payment, (3) its replication of the study in three diverse geographic locations, (4) its inclusion of a large cross-sectional population sampled heavily from patients with chronic disease, and (5) its inclusion of multiple specialties that treat similar kinds of patients.[4]

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In this article, we examine the utilization of hospitals, physician office visits, prescribed medications, and office-ordered selected diagnostic tests and procedures by adult patients. We compare these indicators of utilization among patients cared for by four specialties and across five predominant systems of care that vary in both practice structure and type of payment. Despite considerable past research, there is no consensus as to whether utilization of resources is clearly higher or lower in any one system, or for any one specialty.[1-6] The utilization findings will serve as the backdrop for subsequent comparison of these two important policy-related factors—physician specialty and system of care—with respect to the outcomes of care.

METHODS

The study design, sampling, patient-mix assessment, and data collection methods have been described in the accompanying article by Kravitz et al[7] in this issue of *JAMA*.

Major Study Variables

System of Care.—In the MOS, *system of care* is defined to include the type of practice organization (ie, group vs solo), the physician specialty mix within a group (ie, single vs multispecialty), and the payment arrangements used by patients (ie, prepaid health plan vs conventional indemnity insurance that pays providers on a fee-for-service basis). The patients sampled were classified into one of five systems: (1) the prepaid group practice form of health maintenance organization (HMO), (2) large multispecialty group practice–prepaid, (3) large multispecialty group–fee-for-service, (4) solo or small single-specialty group practice–prepaid, or (5) solo or small single-specialty group practice–fee-for-service. From a physician employment perspective, however, there are generally only three organizational structures—HMOs, multispecialty groups, and solo practice or single-specialty groups. For physicians from the latter two, their practices receive payments from a mixture of arrangements, some prepaid through independent practice organizations and some fee-for-service through traditional indemnity plans.

Utilization Variables.—The measure of hospital care was based on patients' responses to the question, "During the past 12 months, were you a patient in a hospital overnight or longer?" The measure of physician visits was based on patients' responses to the question, "How long has it been since you last visited a medical doctor?" Responses were recorded to provide an estimate of annual visits (interval of <1 month = 12 visits, 1 to 3 months = 6 visits, 4 to 6 months = 2.7 visits, 7 to 12 months = 1.3 visits, and any interval >12 months = 0.5 visits). The time since that last visit reflects the patient's underlying visit rate due to chronic disease and ill health, as well as that due to self-limited illness (ie, a common cold). Although this method does not provide a precise estimate of any one patient's underlying visit rate, there should be no systematic bias with respect to specialty or system of care. Over a population (eg, patients of general internists), the individual fluctuations should average out.

The measure of prescriptions was based on the physicians' responses to the question, "During this visit, did you prescribe any new drug(s) and/or continue any old drug(s)?" The response required a count of the number of drugs prescribed by the physician for that patient.

The measure of diagnostic tests and procedures was based on physicians' responses to the question, "Which of these diagnostic tests and/or procedures (if any) were ordered or performed during this visit?" The form provided a list of common tests and procedures, including complete blood cell count, electrocardiogram, urinalysis, chemistry panel, culture, upper gastrointestinal tract endoscopy, computed tomographic scan, chest roentgenogram, and "other" roentgenograms. We also asked whether any "other" tests and procedures were performed. To create an aggregate measure of these selected tests or procedures (not including the unspecified "other" category), we used the *Physicians' Current Procedural Terminology*, fourth edition,[8] to assign a code to each test or procedure. Each test or procedure was then weighted by a private sector fee derived from the fee schedule of a group practice at a major northeastern medical center. A sensitivity analysis using fees from a large midwestern multispecialty group practice did not alter the results. Aggregate tests per visit were multiplied by visit frequency to generate per capita estimates of the aggregate volume of tests per year. These values serve as a mechanism for weighting the relative value of the selected tests and procedures—not the costs of providing these services.

Other variables included information on age, gender, race, education, family income and size, self-perceived health status, presence or absence of the four MOS tracer conditions (diabetes, hypertension, recent myocardial infarction, and congestive heart failure), the severity of each of these diseases, and a count of other comorbid conditions. These variables are described by Kravitz et al[7] in this issue of *JAMA*.

Data Analysis

The aim of the analysis was to generate accurate estimates of the intensity of utilization in the four specialties and the five systems of care, before and after controlling for the effects of patient mix and sampling methods. Both types of results, that is, those that are unadjusted as well as those that have been adjusted, are useful. The former shows the combined effects of how the systems and specialties work and the "natural" selection of patients into those systems and specialty practices, whereas the latter predicts how the system or specialty would work if equally healthy or sick patients were being seen in each respective system of care and specialty.

The methods used to adjust for design effects (such as correction for "cluster effects" due to correlations among patients of a provider, and weighting for unequal sampling) have been described in the accompanying article by Kravitz et al.[7]

For each of the utilization measures, we excluded cases with missing data on that utilization item. Thus, the sample size varies from utilization measure to utilization measure; sample sizes are reported in the results for each analysis. Most of the missing data occurred for hospitalization, where only a random half of the sample was queried about recent inpatient use. For the specialty analysis we excluded all HMO patients of nurse practitioners. We used the means for site, system, and specialty for missing data on other explanatory values. For these variables, we used regression methods on complete data (eg, age, gender, and other covariates) to impute the missing values.

The purpose of the analysis was to determine how specialties and systems of care influence the utilization of health services. Several different statistical models could be used to estimate how specialties and systems affect use. Studies have shown that the choice of a particular model is important because different modeling assumptions can yield different estimates of the impact of specialty and system on utilization.[9,10]

The results can be sensitive to the choice of statistical model due to the nature of the utilization data. Some of the patients have no "use" at all—for example, only 8% of the MOS patients (unweighted) had been hospitalized during the 3 months prior to their screening. Moreover, among the "users," the distribution of the number of treatments can be very skewed. For example, some patients had made many visits to their

physician in the past month and others had not seen a physician for over 12 months. Because of these two characteristics, analysis of variance models (eg, analysis of variance and analysis of covariance) yield imprecise, though consistent, estimates of the impact of system on utilization even for a large sample of patients.

Because each type of utilization has its own characteristics, our statistical approach varied. For hospital care, we used logistic regression to address the dichotomous nature of this form of utilization. For physician visits, we used least squares regression with the square root of visits as the dependent variable and retransformed the results to obtain estimates of visits made during the past year. We obtained similar, but less robust, results using least squares regression on untransformed visits and the time since last visit. For diagnostic tests and procedures and prescription medicines, we used a variant of the two-part model developed by Cragg,[2] as modified by Duan et al.[3] The zeros in use aspect of the utilization variable was modeled using a logistic regression. Then, among the "users," the skewness problem was overcome by regressing the log of the utilization variable (ie, number of office tests or prescription medicines) on the basic set of covariates.

All of the results below are based on weighted analyses that correct for the disproportionate sampling of individual patients across system, specialty, and time since last visit. The inference statistics have been corrected for the positive correlation in use of services among patients of the same physician. Failure to make such a correction could give the appearance of statistically significant results when the true underlying findings could have been statistically insignificant. Further explanation of the weighting can be found in the study by Kravitz et al[4] in this issue of *JAMA*.

The results that will be presented give two kinds of specialty and system comparisons. The first is an unadjusted comparison based on analysis of variance, where the design effects (such as correlations among patients of a provider and unequal probability of selection in sampling procedure) have been removed, but the effects of differences in mix of patients have not. The second is an adjusted comparison based on multiple regression estimates from the preceding step. For each utilization indicator, we predict the utilization rate, assuming that all patients were in the HMO, then assuming that everyone was a prepaid patient in the multispecialty group, and so forth, for each of the five systems and four specialties. Thus, we achieve comparisons of rates of utilization for the mix of patients that is equivalent across all specialties and systems of care with respect to sociodemographic characteristics, season in which sampling occurred, chronic disease and its severity, comorbid conditions, and health status characteristics. This is similar to standard age-sex adjustment, except that it is done parametrically, controlling for more variables. We follow a similar course in the specialty analyses except that we control for system as well as for specialty; in the system analyses, we do not control for specialty because different systems may elect to use specialties differently.

Table 1—Comparison of Patient Mix and Unadjusted and Adjusted Utilization Rates for Six Indicators Among the Four Specialties*

	Family Physicians	General Internists	Endocrinologists	Cardiologists	P
Patient Mix Indicators					
Mean age, y	40.0	46.9	44.2	56.5	<.0001
Educational level, y	13.6	13.5	14.0	13.1	<.01
No. of chronic diseases per patient	0.70	1.02	1.05	1.32	<.0001
General health perception (0-100 scale)	72.8	67.0	67.9	63.0	<.0001
Unadjusted Utilization Rates					
% Hospitalized	4.20	5.43 (129)†	8.18 (190)†	15.64 (364)†	<.001
Office visits per patient per y	4.53	4.37 (96)	5.57 (123)†	5.19 (115)†	<.001
Prescription drugs per patient	1.18	1.47 (125)†	1.67 (142)†	2.30 (195)†	<.001
% Patients having tests per visit‡	38.6	43.7 (113)†	62.7 (162)†	47.2 (122)†	<.001
Mean value of tests per visit‡	22.00	28.90 (122)†	22.70 (103)	33.80 (154)†	<.001
Mean value of tests per patient per yr‡	85.30	108.80 (129)†	112.60 (131)†	158.80 (185)†	<.001
Adjusted Utilization Rates					
% Hospitalized	4.77	5.58 (117)	7.15 (150)†	10.55 (221)§	<.001
Office visits per patient per y	4.64	4.42 (95)	5.22 (113)†	4.53 (98)	<.001
Prescription drugs per patient	1.40	1.46 (104)	1.54 (110)§	1.74 (124)†	<.001
% Patients having tests per visit‡	40.0	44.2 (111)†	55.9 (148)†	47.7 (119)†	<.001
Mean value of tests per visit‡	23.10	26.40 (114)†	24.00 (104)	34.90 (149)†	<.001
Mean value of tests per patient per yr‡	104.30	110.10 (106)	132.10 (127)†	150.50 (144)†	<.001

*Numbers in parentheses are the ratios of that specialty's utilization rate to that of family medicine, which was set to 100. Samples were chosen by type of utilization: for hospitalizations, 9220; for office visits, 17 585; for prescription drugs, 17 780; for tests and procedures, 17 468. Of the total number of patients studied, 39% were seen by family physicians, 39% by general internists, 6% by endocrinologists, and 7% by cardiologists.

†P<.01.

‡Mean value of tests or procedures.

§P<.05.

RESULTS

Table 1 shows utilization indicator profiles of the four physician specialties. The top panel summarizes some of the critical features of the patient mix that are reported in the companion paper.[1] In the middle panel, for the unadjusted rates, we have arrayed the specialties in relation to family medicine, which was, from past research, expected to be the specialty having the lowest utilization rates, at least for hospitalization, and to have the healthiest, youngest patients. The numbers in the middle panel represent the unadjusted, actual rates of utilization of the six utilization indicators, and the numbers in parentheses represent the ratio of each specialty to family practice, which was set to 100. The use rates for these six indicators of utilization are generally parallel to the mix of patients. Patients of family physicians have the lowest probability of hospitalization—4.30%, the lowest number of prescription drugs per patient—1.18, the lowest percentage of any tests or procedures—38.8%, the lowest mean value of common tests and procedures per visit—22.00, and the lowest mean value of tests and procedures per year—85.30. The office visit rate is similar to that in general internal medicine. Cardiologists have the highest percentage of hospitalized patients, a high number of office visits, the highest level of prescription drugs, and the highest per-visit and annual test and procedure values.

The third panel shows the results after adjustments. The patients of cardiologists and endocrinologists still had considerably higher rates of hospitalization than those of family practitio-

ners and general internists. With the rates of cardiologists and endocrinologists being statistically significantly different from those in family medicine. Cardiologists hospitalized patients at more than twice the rate for family practice, and endocrinologists at a rate 50% greater. With respect to office visits, the two generalist specialties and cardiology were similar, but endocrinologists had statistically significantly higher rates than the others. For prescription drugs, the rates of utilization for family practice and general internal medicine were considerably lower than the rates for the subspecialties. The fraction of patients having tests and procedures, and the mean value of tests and procedures per visit and mean value of tests and procedures per year, were generally lower for the generalists than for the subspecialists. Although the fraction of patients having any tests and procedures per visit and the mean tests and procedures per visit were statistically significantly higher for general internal medicine than for family practice, the per annum difference was not significant, due to the lower number of annual office visits for general internists. As can be seen in the far right-hand column, the overall differences across all four specialties were highly significant statistically.

Overall, after adjustment, family practitioners and internists had only small differences in utilization profiles, while cardiologists and endocrinologists remained considerably higher utilizers than the primary care specialists. This pattern holds for all indicators except for office visits, for which only endocrinologists had higher rates than the primary care specialties.

Because HMOs differ in how they use specialists, the utilization profiles of specialists in non-HMO systems were examined separately. The adjusted results reported above were similar after excluding HMO patients from the analysis. Although the adjusted rates of hospitalization were higher for the three medical specialists compared with family physicians, they retained the same relationship to each other (family medicine, 5.73; general internal medicine, 5.95; endocrinology, 7.83; and cardiology, 10.70 [$P<.001$ for differences among specialties]). General internists had significantly fewer visits (4.39) than family practitioners (4.75) ($P<.01$). The values in this paragraph are not shown in tables.

The effect of system of care on utilization are shown in Table 2, with the top panel summarizing the mix of patients across the five systems, the middle panel indicating the unadjusted utilization rates, and the bottom, the adjusted rates.

Table 2.—Comparison of Patient Mix and Unadjusted and Adjusted Utilization Rates for Six Indicators Among the Five Systems*

	HMO	MSG-PP	Solo/SSG-PP	MSG-FFS	Solo/SSG-FFS	P
Patient Mix Indicators						
Mean age, y	45.0	38.6	42.4	48.8	49.2	<.0001
Educational level, y	13.6	13.8	13.9	13.1	13.6	.001
No. of chronic diseases per patient	0.93	0.88	0.81	0.93	1.10	<.0001
General health perception (0-100 scale)	68.2	71.1	69.0	67.1	67.6	.02
Unadjusted Utilization Rates						
% Hospitalized	4.43	3.60 (81)†	4.35 (98)	5.98 (135)	6.01 (161)†	<.01
Office visits per patient per y	4.35	4.35 (100)	4.21 (97)	4.29 (99)	4.70 (108)	<.001
Prescription drugs per patient	1.31	1.16 (89)	1.21 (92)	1.49 (114)	1.69 (129)†	<.05
% Patients having tests per visit	43.9	37.4 (85)‡	47.7 (109)	41.3 (94)	47.4 (108)	<.05
Mean value of tests per visit	26.30	20.50 (78)‡	25.70 (98)	23.30 (89)	28.30 (108)†	<.05
Mean value of tests per patient per yr	105.70	82.40 (78)	94.90 (90)	91.10 (86)	122.30 (116)	<.01
Adjusted Utilization Rates						
% Hospitalized	4.93	4.24 (86)	4.92 (100)	5.58 (113)	6.94 (141)‡	<.05
Office visits per patient per y	4.68	4.73 (101)	4.33 (93)	4.17 (89)†	4.30 (92)‡	<.001
Prescription drugs per patient	1.37	1.45 (106)‡	1.32 (96)	1.48 (107)‡	1.53 (112)†	<.01
% Patients having tests per visit	43.6	38.4 (88)	46.8 (110)	42.1 (96)	47.9 (107)	.06
Mean value of tests per visit	26.10	22.40 (86)	26.50 (102)	24.50 (94)	27.40 (105)‡	<.01
Mean value of tests per patient per yr	116.40	103.70 (89)	110.80 (95)	91.70 (79)†	113.80 (98)	<.05

*HMO indicates health maintenance organization; MSG-PP, multispecialty group–prepaid; Solo/SSG-PP, solo practice/single-specialty group–prepaid; MSG-FFS, multispecialty group–fee-for-service; and Solo/SSG-FFS, solo practice/single-specialty group–fee-for-service. Numbers in parentheses are the ratios of that system's utilization rate to that of the HMO, which equals 100. Sample size varies by type of utilization for reasons explained. 9436, for office visits; 10 353, for prescription drugs; 10 573, for tests and procedures; 10 308, Of the total number of patients studied, 37% were in HMOs, 10% MSG-PP, 12% Solo/SSG-PP, 6% MSG-FFS, and 34% Solo/SSG-FFS.

†$P<.01$.

‡Mean value of tests or procedures

§$P<.05$.

In the middle panel, unadjusted utilization rates for four different systems are shown in relation to the HMO, with the ratio of the rates of the other systems to the HMO noted in parentheses. We chose the HMO as the comparison group because of its historically low hospitalization rates. The two fee-for-service systems have higher rates of hospitalization and prescription drug use than the HMO, multispecialty group–prepaid, or solo practice/single-specialty group–prepaid patients, with solo practice/single-specialty group–fee-for-service having statistically significantly higher rates than the HMO. Office visit rates for the non-HMO systems are not significantly greater than those for the HMO. While the mean value of common tests and procedures per visit is lower in multispecialty groups–prepaid and higher in solo practice/single-specialty groups–fee-for-service than in HMOs, the remainder of the systems show no major trends in these unadjusted data.

The bottom panel shows the utilization rates adjusted for sociodemographic status, MOS tracer disease presence, MOS tracer disease severity, chronic comorbid conditions, general health perceptions, and the season in which sampling occurred. The results are not adjusted for specialty because the mix of specialists hired may be one method of resource allocation used by different systems. The middle and bottom panels differ because of the patient mix differences as seen in the top panel. The patient mix differences explain part, but not all, of the differences between systems. Large multispecialty group–prepaid and HMOs have the lowest hospitalization rates, which are not significantly different from each other. Solo practice/single-specialty groups–fee-for-service have the highest adjusted probability of hospitalization, 6.94%, which is statistically significantly different from, and over 40% higher than that of HMOs. For office visits, HMOs and large multispecialty groups–prepaid are again similar but have statistically significantly higher rates compared with the multispecialty group–fee-for-service and the solo practice/single-specialty group–fee-for-service. The number of prescription

drugs was higher in the solo practice/single-specialty group–fee-for-service and the multispecialty group–fee-for-service than in HMOs. Test and procedure ordering data in the four systems revealed few differences compared with HMOs. Except for the percentage of patients having any tests, there were significant differences among the systems in the overall analysis for each of the utilization modalities. Often the comparisons with HMOs were not statistically significant because HMO rates were in the middle.

Because HMOs combine both organizational and payment features, we attempted to isolate the effects of each. We grouped the non-HMO prepaid patients from the large multispecialty groups and solo practice/single-specialty groups and compared them with fee-for-service patients from both large multispecialty groups and solo practice/single-specialty groups. Then we compared the large multispecialty groups across the two forms of patient payment with the solo and single-specialty practitioners across the same two forms of payment. We treated HMO patients as a separate group. The findings showed that fee-for-service patients had significantly higher probabilities of hospitalization than did prepaid patients, independent of the type of physician organization. Solo practice/single-specialty group patients had significantly higher rates of hospitalization than multispecialty group patients, independent of the payment system. However, there was a significant interaction effect between payment and organizational features: visits in solo practice/small single-specialty groups–fee-for-service were not as low as one would expect based on the overall effects of (1) fee-for-service vs prepaid and (2) solo practice/small single-specialty vs large multispecialty group. For prescriptions and test and procedure ordering, there were different payment and organizational effects. For prescriptions, there was an interaction of payment and organization, namely, solo practice/single-specialty group and fee-for-service had a higher combined effect. For test ordering, fee-for-service had higher rates than prepaid, and solo practice/single-specialty group patients had higher rates than multispecialty group patients.

The demographic (age, gender, and race) and socioeconomic (family income and size and schooling) variables as a group were statistically different from zero in each of the equations that we estimated. These variables were significant, even when patient mix and system of care were controlled for. However, individual covariates differed in their results. Gender was not significant for inpatient care, or for prescription drugs or mean tests or procedures; however, men made significantly fewer visits. Socioeconomic status was significant except for mean tests and procedures, and there was a borderline result for hospitalization.

We included two variables to capture the effect of the season of the year during which the survey was administered; this enrollment date varied with study site and the system of care within each site. The seasonal terms were not significant for visit rates and the likelihood of hospitalization but were significant for the likelihood of a prescription drug or a test or procedure. In those cases where seasonality was statistically significant, the inclusion of the seasonal variables did not alter the qualitative results.

COMMENT

Many factors can influence utilization, including uncertainty about the most effective practice, responses to regulations, legal concerns such as malpractice, patient and societal expectations to apply more and more technology, method of patient payment to physician, and type of patient insurance coverage. Many of these factors may express themselves in a "final common pathway" that encompasses both professional socialization (ie, physician specialty) and the system of care in which the physician works. In theory, one factor above all others, patient need, should be driving variations in utilization at any given time. In this study we controlled for patient need by adjusting for patient mix and then examined the impact on utilization of physician specialty and the system of care in which the physician works. We separated system of care into two components—organization, on the one hand, and payment on the other. The MOS has been designed to provide empirical evidence for these alternative forces that drive health care costs.

Patient mix, besides having a strong influence on the patient's selection of medical specialty and system of care, also was a powerful determinant of the quantity of health care resources utilized in this study and others.[7,8,10] However it was not the only determinant. Therefore, in determining the independent effects on utilization of specialty, practice organization, and payment method, adjustments must be made for patient mix. Differences in patient mix appear to explain a substantial part of the differences in utilization rates across system and specialty. For example, unadjusted hospitalization rates were 81% higher for solo practice/single-specialty groups–fee-for-service than for HMOs, but adjusting for case mix reduces the difference to 41%. Internists were 26% more likely to hospitalize than family practitioners; after case mix adjustment, the difference was a statistically insignificant 17%.

Physician Specialty

Prior research suggesting that physician specialty, by itself, has a major impact on utilization is unconvincing. Many comparisons have been made between general internists and family physicians; the majority of these studies have suggested greater resource use by internists.[9-16] Two of the more extensive studies[11,13] used data from the National Ambulatory Medical Care Survey and concluded that family physicians ordered fewer diagnostic tests and spent less time with patients than did internists. Both studies attempted to control for patient mix using unstandardized global ratings from physicians. Unfortunately, case mix information obtained in this way may relate more to variations in how specialists view severity than to actual patient mix differences. Further, these studies did not control for system of care, nor did they evaluate hospitalization rates. A more recent study concluded that internists order more tests and hospitalize more patients than family physicians.[16] While that study employed somewhat more objective measures of patient mix, it examined a preponderance of rural practitioners, thereby limiting its generalizability.

From our data we draw two conclusions about the effect of specialty on utilization. First, large differences in patterns of utilization of health care resources were observed when comparing the actual (unadjusted) practices of these four specialties. These differences are consistent with patient mix differences among the four specialties. Second, after adjusting for patient mix, variations in utilization remained. General internists had utilization rates for most indicators that were somewhat higher than those of family physicians, but the differences did not consistently reach statistical significance; cardiologists and endocrinologists had utilization rates that were considerably higher than those of both of the generalists. Specialty, therefore, had an independent effect on utilization, with the subspecialists being higher users than the generalists. Our results are presented conservatively by comparing other specialties with family practice. Because of our focus, we have presented our specialty comparisons as family practice vs all other specialties. There may have been differences among other specialties that would have been

revealed in multiple pair-wise comparisons. Because of the problems with precision of estimates involved in these comparisons, and the absence of a priori hypotheses, we did not perform these analyses.

Before turning to the discussion of systems of care, we would like to acknowledge some of the important limitations of the results linking specialty to utilization. One is that some patients might have been managed simultaneously by more than one physician. Consequently, the utilization indicators derived from patient reports could distort the actual amount of utilization "directed" by the physicians in our study. Second, the charges for hospitalizations were not measured; it is possible that the duration and the content of the hospitalizations varied by specialty in ways unknown to us. Third, we did not measure all kinds of office-ordered tests—only the most common ones typically used in practice, and it could have been that, even after adjustment for patient mix, certain specialties had different patterns of use of rarer, but more expensive and more invasive, tests and procedures. Fourth, there were smaller numbers of endocrinologists and cardiologists than of generalists. Finally, the physicians in the MOS sample were recruited with the help of their respective specialty societies or by the management of their practice organization, and because participation in the MOS was voluntary, study physicians may have had different training and motivational qualities than other physicians nationally. However, we do not expect that these selection differences, if they existed, would vary across specialties. These limitations need to be addressed in future research.

System of Care

The analyses that link system of care to utilization rates show that both practice organization and payment method have independent effects on utilization. For example, practice organization, after adjustment for patient mix, has an effect independent of payment method on hospitalization rates, with the multispecialty groups and HMOs having the lowest, and solo practice/single-specialty groups the highest, rates.

System of Care and Hospitalization.—One of the major policy-relevant comparisons that can be made in the MOS is the contrast between HMOs and solo practice/single-specialty groups—fee-for-service; after adjusting for patient mix, solo practice/single-specialty fee-for-service patients had hospitalization rates 41% greater than HMO rates, and the patients were taking 12% more prescription drugs. However, HMO patients had 8% more visits with their physicians per year than solo practice/single-specialty-fee-for-service patients. In this and in some other examples, there appears to be a reciprocal relationship between hospitalization rates and office visit rates.

To provide a purer test of practice organization vis-a-vis payment method, we compared multispecialty groups to solo/single-specialty group practices after controlling for payment method. After adjustment for patient mix, the solo/single-specialty form of practice organization had higher rates of hospitalization than multispecialty groups. Perhaps the availability of ancillary and specialized services and the completeness of off-hours physician call schedules within large group practices generate a degree of patient management efficiency with out-of-hospital care that was not present among solo/single-specialty group physicians.

Payment method, after adjustment, also had an independent effect on utilization. Prepaid patients, compared with fee-for-service patients, experienced reduced rates of hospitalization and higher rates of office visits. These findings are not surprising, given the incentives in prepaid plans to restrain the use of the hospital.

The low hospitalization rates achieved by HMOs is consistent with most of the early observational studies showing that HMOs make less use of the hospital—10% to 40% fewer hospital days and about 25% lower hospital admission rates.[2,5] Two observational studies conducted in the 1980s came to different conclusions.[20,21] However, the investigators in these studies may not have been able to control adequately for unobserved case mix variables, and the result may not be generalized to cities other than those in which the studies were performed.

The Health Insurance Experiment, which was conducted in an earlier period, is the only randomized trial relevant to this issue.[22] Seattle (Wash) residents were assigned to either HMO or fee-for-service systems of care. The experimental results showed that HMO patients had 40% lower admission rates and the lower rates tended to be due to less provision of discretionary care.[23] Specific types of patients with serious problems such as colorectal cancer and rheumatoid arthritis have been studied in observational research.[24] In these diagnosis-specific studies, there were only small differences between fee-for-service practices and HMOs in hospital utilization. The results reported herein are more consistent with the general population studies than with the diagnosis-specific reports. This suggests that differences in admission rates may reflect discretionary utilization in general populations.

The one-third lower hospitalization rate in HMOs and other prepaid plans could, potentially, affect "downstream" health outcomes.[25,26] Future reports from the MOS with longitudinal follow-up over 4 years will attempt to shed light on this critical question.

System of Care and Other Forms of Utilization.—Although there has been extensive research on the question of whether HMO patients have more or fewer office visits than fee-for-service patients, the results have been mixed.[4,16] Our results indicate that HMO patients, after adjustment, have 8% more physician visits per year than solo practice/single-specialty fee-for-service patients. The size of this difference is not large, but considering that Americans make over 1 billion visits per year to physicians, even small percentage differences can lead to large dollar differences.[11,12]

Fee-for-service patients—in solo and single-specialty group practices—had more medications prescribed both before and after adjustment than HMO patients. Once again, the magnitude of these percentage differences (12% after adjustment) is not as large as that seen for hospital care, but the financial impact may be substantial. After hospital care and physician services, the nation spends more of its health care dollars on prescription medications than on any other category of care.[11,13]

As with specialty, using HMOs as the comparison group understates differences in utilization rates among systems, because the HMO was not always the most extreme in its use pattern.

Utilization Incentives

Prepaid and fee-for-service systems operate under overarching financial incentives that are different and likely to influence utilization of services in opposite ways.[11,27] In theory, clinicians in prepaid systems will, other things being equal, tend to recommend less care—to "conserve" valuable resources—whereas practitioners in fee-for-service systems will tend to recommend more tests and procedures. A recent small study supports this assertion.[28] Patients in prepaid systems may demand more care, whereas fee-for-service patients will tend to avoid care if additional payments from them, over the fixed premium, are required. Because the out-of-pocket costs to patients are lower in HMOs, price acts as less of a deterrent to patient-initiated visits.

The method of payment of physician income can provide indirect or direct incentives to conserve or expand health

care resources.[34] For example, physicians who are paid a "straight" or "fixed" salary may, other things being equal, be less likely to hospitalize patients. Other physicians who are paid on a salary adjusted upward for generating patient revenues may tend to hospitalize more or to order more services, whereas those on a salary adjusted downward for utilization of services may tend to conserve.

The results observed in this study suggest that physician specialty, organizational structure, and payment methods, acting independently, provide incentives that influence utilization patterns regardless of patient health status. The observation that HMOs use less hospital care and fewer prescribed medications conforms to conventional wisdom about the impact of incentives on these systems.

The limitations of this study need to be recognized. First, there may be yet unmeasured patient mix differences. The analyses show clearly the need to use comprehensive patient mix adjustment on utilization data when comparing systems and specialties. There were substantial differences between the unadjusted and adjusted results in most analyses. We believe that patient mix adjustment must reflect the full interplay of diagnoses, disease-specific severity, health status, and well-being, as well as sociodemographic differences. Ongoing research in the MOS longitudinal study will make use of clinical and laboratory findings to enhance patient mix adjustment.

Second, although varying patterns of utilization emerged from the results, we have not provided any overall estimate of annual per capita costs, or of health benefit. These estimations are beyond the scope of this study.

Third, it is important to avoid the temptation to overgeneralize these results. The study was conducted in only three urban areas, was limited to only four specialties providing care in selected settings and systems, and included a highly select group of patients.

In conclusion, alternate medical specialties and systems of care clearly do use health care resources differently. What remains to be learned is the effect of these patterns on health outcomes and patient satisfaction with health care services. Later publications from the MOS will address those topics. Meanwhile, the two MOS articles in this issue of *JAMA* provide evidence that (1) patient mix is a powerful determinant of care—it both sorts patients to different care providers and may account for a major share of the utilization variation observed in different specialties and systems; (2) even after adjustment for patient mix, substantial variations in utilization remain; (3) subspecialists use services more intensely than generalists; (4) fee-for-service systems, even after adjustment for patient mix, have higher use rates of hospitals and prescription drugs than HMOs and other prepaid systems; (5) physician organization and payment method each play an independent role in influencing utilization, with solo practice and single-specialty groups and fee-for-service payment favoring higher use rates. The implications of these findings for public policy must await outcomes data and other information on the trade-offs between costs and benefits.

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Specialists or Generalists

On Whom Should We Base the American Health Care System?

One of the enduring debates in American medical policy is whether the United States should build its medical care system on a foundation of medical generalists or rely instead on more narrowly defined specialists.[1,2] For the most part, we have taken the latter road.[3] Despite 21 years of federal programs designed to increase the production of primary care physicians, most physicians select specialty careers, a trend that has accelerated with declining match rates in primary care fields in recent years.[4]

Although the debate has been both loud and long, the evidence available to resolve this issue rationally has been somewhat meager and frequently flawed. It is very difficult to determine exactly what physicians do, much less how much it costs or how profound its impact. Answering these questions is difficult, methodologically treacherous, and enormously expensive. Unlike a population of laboratory animals, physicians are reluctant and often fractious experimental subjects. To make it more difficult, patients are not randomly assigned to physicians. Disease severity, functional health status, and social class are all important in determining which

See also pp 1617 and 1624.

patients are cared for by which physicians. Simply comparing physician performance without taking these factors into account can be very misleading.

The Medical Outcomes Study (MOS)[5,6] is the first large-scale attempt to unravel all these potentially confounding variables simultaneously and focus on the core questions: do specialty and organizational setting matter? Not only did the study team need to recruit hundreds of randomly selected physicians and thousands of patients in three major cities in the United States, but they also had to create state-of-the-art tools to measure disease severity and functional health status, accomplishments that may ultimately be as important as the study itself. Although there are flaws in the study—from the low response rates of solo practitioners to the rather unrepresentative cities in which the study was done—no one is likely to ever do a better job.

In this issue of THE JOURNAL, two articles from the MOS report results with important implications for the future of our health care system.[7,8] One major finding of the MOS[7] reaffirms what we have learned from other studies of national physician samples: patient mix does differ with both the specialty and the organization of care, and sicker patients use more medical resources.[9,10] There seems to be a tendency for older and sicker patients to gravitate to more specialized physicians, a mutual attraction that makes sense but must be interpreted cautiously, given the limited number of specialties studied and the geographic peculiarities of the sample. Whether or not this observation is true nationwide, these MOS results establish that one cannot do comparative studies of the costs and outcomes of medical care without controlling for patient mix, broadly defined.

But the second finding[8] is both more novel and of greater policy significance. Even after the authors controlled for patient mix, endocrinologists and cardiologists tended to use more resources than general internists, and general internists tended to use more resources than family physicians. Organizational setting had an additional but independent effect. How you were trained and where you work affect your style of practice. Given that the findings are dramatic, there are four questions we should ask: Are the findings correct? Are they generalizable? Does the increased resource use benefit patients? And what are the implications of these findings for the health care system?

First, the findings are persuasive. In fact, the differences in utilization almost certainly understate the true differences in cost between specialists and generalists. This study measures resource use, not charges, and specialists charge more—and are paid more—for the identical services provided by generalists.[11] Despite the methodological limitations of the study, the power and persistence of the findings suggest that they reflect reality.

The problem of generalizability is more problematic. Boston, Chicago, and Los Angeles have little in common with many medium-sized cities in the United States, to say nothing of the rural hinterlands. The roles and relationships of both physicians and the organizational settings in which they

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work may vary, and it is possible that the findings in this study would not be replicated in places where generalists are more numerous, or where specialists provide less primary care.

Whether the increased intensity of resources affects biological outcomes or patient satisfaction will be the subject of the final phase of the MOS. It may be that the additional resources expended make such profound differences in health status that they represent a prudent investment of resources. However, given the relatively modest effects of different kinds of insurance systems on health status in the RAND Health Insurance Study,[12] we should not be surprised if additional resources are not correlated with better outcomes.

The findings of the MOS help to explain the observation that the other English-speaking industrialized nations manage to provide universal health care access to their citizens, achieve excellent health care outcomes, and spend dramatically less per capita than does the United States. Canada, Great Britain, New Zealand, and Australia all depend on general and family physicians for virtually all their primary health care, and in each country approximately half of all physicians are generalists.[13,14] As we examine the quality of medical care provided by different specialties, it is important to remember that a substantial proportion of our population has limited access to any health care provider, at least in part because the existing system consumes more resources than our society is willing to expend. Substituting generalists for specialists may be an essential component of any solution to this problem.

In the final analysis, the MOS suggests that one way to gain some control over escalating health care expenditures is to pay attention to the mix of physicians providing health care and the way in which they are organized. This study corroborates earlier observations that health maintenance organizations and multispecialty groups are more economically efficient in their provision of care. Just as important, broadly trained generalists appear to be more parsimonious in their use of medical resources than their more narrowly trained specialty colleagues. Given the inexorable fact that our nation must limit its expenditures on medical care, it is time to increase the proportion of physicians entering generalist disciplines.

Roger A. Rosenblatt, MD, MPH

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Epidemiology and the Human Immunodeficiency Virus

Clinical Effects of Intravenous Drug Misuse

The human immunodeficiency virus (HIV) epidemic has repeatedly highlighted the many contributions of epidemiologic research to our understanding of the disease process. For example, substantial differences in clinical manifestations between HIV-infected subgroups may indicate a correlation between host response and disease pathogenesis. Kaposi's

See also p 1631.

sarcoma, as one case in point, is speculated to be caused by a second sexually transmitted agent primarily because of the unique concentration of this opportunistic malignancy in homosexual men. On the other hand, HIV-related non-Hodgkin's lymphoma occurs with similar frequency in all subgroups and so is considered to arise as a more direct consequence of HIV infection. Clearly, epidemiologic observations can assist us in directing our search into the pathogenesis of these diseases. Epidemiologic findings also have clinical implications. The critically important use of infection prophylaxis relies on data from cohort studies that allow us to predict the risk of specific opportunistic diseases based, for example, on CD4 cell counts.

In this issue of *JAMA*, Margolick et al[1] illustrate yet another area in which we benefit from epidemiologic research. They set out to investigate the hypothesis that the rate of HIV disease progression would be influenced by the continued misuse of intravenous drugs. This general topic—comparing disease progression rates in HIV-infected subgroups—also has the potential to teach us a good deal about pathogenesis. In addition, it has been the center of much clinical controversy. What, for example, should we advise our patients about the consequences of continued drug misuse in

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Senator Mikulski. As you know, I am Egon Herthamer, doctor of optometry, in private practice in Baltimore, Maryland. I appreciate the opportunity to appear before you to discuss health care reform and how I feel it will affect optometry.

As a health care practitioner and a health care consumer, I am very interested in the issue of health care reform. I am particularly interested in how any reform will affect the public's access to eye care.

As part of any discussion, I believe there are some basic tenets that must be addressed. These tenets include broader access to health care coverage, assurance of quality care and some cost containment measures.

Access to health care should be available to all U.S. residents regardless of race, sex, religion, age, income, insurance status, and geographic location. Certain underserved populations should be targeted to receive essential health services. One way to improve access is to allow the patient to select the provider of their choice.

There should be an emphasis on promoting and maintaining health through primary care and the expansion of public health functions for disease prevention. By promoting primary health care, the U. S. health care system can become proactive rather than reactive. This would reduce more costly care that is many times necessary when a condition or disease has progressed beyond a certain stage.

Cost effectiveness should be promoted. Cost effectiveness can be accomplished through quality care measures and efficient management of the health care system. By putting in place quality assurance standards for all providers through outcome studies and new technology assessment, the health care system will become more efficient and more cost effective.

One last tenet that needs to be emphasized is support for basic health research. By supporting basic health care research, the delivery of quality health care can be improved so access can be increased and costs can be reduced.

But as I said before, as a provider of eye health care services, one of my concerns is the delivery of eye care services to the public. Because of this concern, I would like to discuss, first, the inclusion of optometric services in any national health care reform. Secondly, I would like to discuss the preservation of freedom of choice laws or mandated provider laws which are many times lumped together with mandated benefit laws.

NATIONAL HEALTH CARE REFORM

Whatever direction the health care debate takes, I would like to recommend that any legislation that is enacted include optometrists as equal providers who can provide services as authorized by state law. The best argument for this inclusion is Medicare which defines optometrists as physicians for all covered services within their state scope of practice act.

Other actions taken by government agencies and commissions have also supported the concept of inclusion of optometric services in national health care reform. Most recently, the Physician Payment Review Commission has declared that optometric services are the same as those provided by doctors of medicine or osteopathy and should be paid on the same basis. The Health Care Financing Administration has also said that under the new Medicare fee shedule optometric services will be valued the same as physician services. With these examples of federal recognition of optometric services being equal to physicians' services, it naturally follows that optometry should be included in any national health care legislation as an equal provider.

FREEDOM ON CHOICE LAWS

In many of the health care reform proposals that have been introduced at both the state and federal level, there are provisions to eliminate mandated benefits because of their effect on the cost of health care. What I would like to do is point out the difference between mandated benefit laws and freedom of choice laws, and how freedom of choice laws actually improve the delivery of health care.

There has been great confusion between mandated benefit laws and freedom of choice laws. Mandated benefit laws actually require that a health care plan cover certain benefits such as coverage of mental health. Freedom of choice laws only require that there be no discrimination of providers for services that are already covered by a health insurance plan. In the current environment surrounding mandates, I believe that is an important distinction.

Unlike the mandated benefit laws, the freedom of choice laws do not require that a health care plan cover any particular illness or condition. For example, with respect to eye care, the freedom on choice laws do not require that a plan cover eye care at all. If a plan covers particular aspects of eye care, the freedom of choice laws do not dictate which types of eye diseases or eye conditions or eye examinations shall be covered or with what frequency such coverage must be made available to the employee.

Throughout the nation it is evident that these freedom of choice statutory provisions have been enacted to assure the patient his or her unrestricted access to care covered by insurance plans. All 50 states and the District of Columbia have some form of freedom of choice legislation. With respect to eye care services, there are a multitude of statutes which require the reimbursement of the patient who prefers to use the services of an optometrist, as long as the services are authorized by the laws of that particular state.

BARE BONES COVERAGE

A handful of states have taken the approach of reducing or eliminating mandates to encourage small firms to offer health insurance. Unfortunately, freedom of choice laws have erroneously been included in this effort. Freedom of choice laws should not be included in this rush to cut back on mandates. Organizations as varied as the Health Insurance Association of America, the Families USA Foundation, and the American Association of Retired Persons have commented that such a rush to judgement on mandates is no panacea for small employers and will not solve the problem of rising health costs. Eliminating freedom of choice laws may actually exacerbate the problem because these laws increase competition and assure access.

PRO-COMPETITIVE AND COST EFFECTIVE

Freedom of choice laws benefit the consumer and promote competition by allowing the patient a choice of providers licensed to provide the care. The freedom of choice laws are aimed at protecting patients by assuring that more widespread eye care is available. In many instances, the freedom of choice statutes may save the health care system by reducing visits to emergency rooms or other specialists who may be higher cost providers. By promoting competition among providers, the health care system will ultimately benefit.

The argument has been made many times that freedom of choice laws add new and additional services to health care costs. This simply is not true. These services are services that were already covered by the health insurance plan. Freedom of choice laws merely provide the patient with a choice where more than one provider is licensed to provide the same service. Optometrists in a majority of the states are licensed to diagnose and treat eye diseases and infections. These services have always been covered; they are not "new" or "additional" services. It is important to note that any potential new costs associated with freedom of choice statutes are not new at all, but are the result of beneficiaries receiving care under the plan that they may previously have paid for out of pocket, or worse, did not seek because of the restrictive nature of their benefit plan.

ACCESSIBILITY

Access to eye health care services can be improved through freedom of choice laws. Optometric services are available in approximately 6,400 communities in the U.S. In 4,000 of these communities, doctors of optometry are the only primary care provider. In many instances, freedom of choice laws make available services that patients would not have access to otherwise. This is especially true in rural areas. In communities where there are no eye care practitioners besides an optometrist, the patient my go without eye care, travel long distances for eye care, or incur out of pocket expenses to travel to other communities for eye care.

Because optometrists are geographically accessible throughout the U.S., freedom of choice laws can actually save money for the patients and the health care system by reducing patient out of pocket travel expenses, additional visits to the doctor, and valuable time away from work.

Optometrists provide approximately 60 percent of the primary diagnosis eye examinations in the U.S. Thus, many people who need eye care are relying on optometrists to provide such care. Without freedom of choice laws, many of these people will not receive the eye care they need.

Failure to maintain access to non-M.D. health care providers in any national health care reform legislation seriously jeopardizes access to not only those who are already covered by health insurance, but also the 37 million workers who are currently uninsured. Moreover, eliminating competitive alternatives to physician providers will inevitably frustrate efforts to control overall health care costs. The history of health care bears strong witness to the fact that, without the inclusion of non-M.D. providers such as optometrists, patients may be denied access to care. Thus, the health care delivery system becomes worse, not better.

SUMMARY

Unfortunately, the problem of rising health care costs and the access to the health care system by the 37 million uninsured and 40 million underinsured will not be solved easily. The latest report from the U.S. Department of Commerce predicts health care spending will total $817 billion in 1992 or 14 percent of the country's gross national product. This translates into Americans spending nearly $1.4 million per minute on medical care. Not surprisingly, we spend more per capita on health care than any other country which effects our competitiveness in the world market.

Hopefully, by incorporating the principles I have outlined, the health care system will become more efficient making it more cost effective and more accessible. This in turn will halt the galloping cost of health care and help to make the U.S. more competitive in the world market. As only a small part in this giant system, I want to do what I can to make optometry part of the solution, not part of the problem. Senator Mikulski, I appreciate the opportunity to present my views to you today.

Prepared Statement of Margery F. Rodgers
Maryland Occupational Therapy Association

My presentation today represents the views of the Maryland Occupational Therapy Association the American Physical Therapy Association of Maryland and the Maryland Division of Rehabilitation Services. We represent rehabilitation professionals providing services in hospitals, rehabilitation centers, nursing homes, home health, and public and private practices.

Our three associations advocate reform which incorporates the principle of universal, nondiscriminatory access to a continuum of comprehensive benefits ranging from preventative to continuing care services. Assured appropriateness and quality of care, improved system efficiency and equitable cost-containment should also be central goals of health care reform. Inherent in these principles is, in our view, a need to recognize medical rehabilitation as an essential ingredient of basic, cost-effective, quality health care. While many of the legislative proposals pending before the Congress contain positive and constructive features that are consistent with the principles we believe are necessary to effective reform, others fall short in their efforts to address fundamental health care needs.

MEDICAL REHABILITATION SERVICES

Rehabilitation services are individualized, goal-oriented medical services which are designed to maximize functional ability and promote quality of life and independence for individuals who, whether through accident, illness, congenital condition or birth injury have acquired a temporary or permanent disability. These services are multidisciplinary in nature and are provided by qualified health care professionals including occupational therapists and physical therapists.

Medical rehabilitation services are available in a variety of delivery settings, depending on diagnostic and therapeutic requirements. These include freestanding rehabilitation hospitals, rehabilitation units in acute care hospitals, nursing facilities, comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies and clinics, home health agencies and the offices of qualified independent practitioners.

NEED FOR REHABILITATION

It is estimated that over 253,000 Marylanders between the ages of 18-64 have conditions that interfere with their life activities and more than 125,000 are severely disabled preventing them from working, attending school or maintaining a household. The numbers of Americans with disabling conditions are projected to increase significantly due to factors such as medical and technological advancements which save and prolong life, and the aging of our population. Medical rehabilitation services have proven to be a necessary and cost-effective treatment for the conditions that can prevent Americans from maximizing their potential.

Persons benefiting from rehabilitation services include, individuals who have sustained a heart attack or stroke; have arthritis, cancer or a neurological disorder; have undergone amputations or joint replacements; have developed sensory deficits and/or chronic intractable pain; have experienced a traumatic accident or a debilitating illness or suffer from chronic pulmonary disease; and children who are born with or develop physical impairments. Medical rehabilitation speeds recovery, prevents recurrence or rehospitalization and maximizes the restoration of functional capacity. Rehabilitation services are essential to ensure that these individuals can function as independently as possible and return to their homes, communities and jobs.

COST EFFECTIVENESS

Rehabilitation has proved a cost-effective alternative to extended institutional acute care. as a variety of studies have demonstrated. For example, a survey conducted by the Health Insurance Association of America (HIAA) of its member companies found a savings of $11 for every $1 invested in rehabilitation services, and a savings per claimant of between $1,500 and $250,000. Similar results have been demonstrated in studies conducted by insurance and case management companies.

Under the current system insurance premium costs associated with coverage of medical rehabilitation services are extremely modest when contrasted with potential cost savings and the enhanced quality of life patients can achieve with the availability of such services. For example, according to 1990 figures from Blue Cross-Blue Shield of Massachusetts the cost of full coverage in inpatient and outpatient settings of occupational therapy, physical therapy and speech-language pathology services amounted to 1.5 percent of the average individual monthly insurance premium, or $3.75 (Source: Blue Cross and Blue Shield Association, Washington, DC/Figures are a composite rate combining all groups).

RECOMMENDATIONS FOR REFORM

We endorse the following principles and recommend that Congress incorporate these elements into any health care reform initiative:

Universal Access/Nondiscrimination

All Americans, regardless of age, income, disability or employment, must have access to a basic package of appropriate, affordable, quality health care. Access should be based on health care need as opposed to employment status or income level. Discriminatory health insurance industry practices should be eliminated. Arbitrary rating and underwriting practices, such as exclusions based on preexisting health conditions and waiting periods, are unfair and particularly discriminate against persons with disabilities. Continuity and portability of coverage should be assured for all Americans.

Comprehensiveness

Health care reform should insure the availability of a full range of services necessary to provide a continuum of quality care, and should provide adequate access to these services in the most appropriate settings. A core health benefits package must include coverage of medical rehabilitation services in hospital and home and community-based settings. Benefits should also include coverage for items that are critically important to achieving functional independence such as prosthetics, orthotics, durable medical equipment and assistive technology.

Quality/Appropriateness of Care

The promotion of appropriate, quality care is essential to a health care system that values outcomes while containing system costs. A central element of reform should be accelerated efforts to develop research-based, multidisciplinary practice protocols to verify therapeutic effectiveness and provide guidance to practitioners and consumers alike. From the medical rehabilitation perspective, measures of quality and appropriateness should be based upon defined standards of care which incorporate uniform functional assessment and outcomes measures.

We support a coordinated health care system that assures individuals the type and level of treatment most appropriate to their medical condition. However, we are concerned that flaws inherent in many of today's managed care models would be continued and promoted by health reform proposals that mandate managed care. Certain current and contemplated forms of managed care can create disincentives for treating persons with disabilities and other persons suffering from severe disease or injury. Neither managed care nor individual case management should be considered a panacea in the quest for reform of the health care system. Case managers must be trained professionals with a clinical understanding of rehabilitation and the unique health care needs of persons with disabilities to assure appropriate, quality care. As you well know, there continues to be a critical need for additional rehabilitation professionals. As Congress considers legislation authorizing support for allied health care personnel, we urge that priority be given to funding schools of physical therapy, occupational therapy, rehabilitative nursing, speech pathology and audiology.

Efficiency and Equity

An efficient and equitable health care system should appropriately distribute resources, as well as responsibility, and must include effective and fair cost-containment mechanisms.

A balanced health care system demands that emphasis and resources be distributed along a continuum of care, beginning with preventive services and including acute care, rehabilitation and continuing care services.

Health care reform must provide incentives to reduce unnecessary or duplicative health care and administrative costs. Cost containment efforts should not be based on inadequate reimbursement for health care providers or limited, non-comprehensive benefit packages. Efforts to control system costs predicated on non-comprehensive benefit packages and insufficient reimbursement for health care providers will not promote system efficiency and will stifle efforts to promote quality care and successful health outcomes for all Americans.

The Senate Democratic leadership has introduced significant legislation to begin the process of health care reform.

We believe that S. 1227 contains many positive features that are consistent with the principles necessary for effective reform. We believe, however, that refinements to the proposal are essential if it is to meet the stated goal of providing access to quality, cost-effective health care for all Americans.

Specifically, the revised version of S1227 that has been reported by the Labor and Human Resources Committee provides inadequate coverage of medical rehabilitation services under both the employment-based benefits package and AmeriCare, the public health insurance plan. **In fact, the benefits package envisioned in S. 1227 would represent a significant step back from current coverage of medical rehabilitation services under public and private insurance plans.**

Employment-Based Coverage - The employment-based benefits package requires coverage of hospital and physician services, diagnostic tests, limited mental health benefits, pre-natal and well-baby care and some preventative services. **Medical rehabilitation services are omitted from the specified benefits included under employer-based coverage.** Based on discussions with Senate Labor and Human Resources Committee staff, **hospital-based** inpatient and outpatient rehabilitation services are presumed to be included in S. 1227 because they fall under the definition of hospital services as traditionally defined by the insurance industry and the Social Security Act. However, community-based rehabilitation services, such as those furnished by comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies and clinics and independent practitioners would not be covered.

Public Plan - AmeriCare, the public health insurance plan, would replace the existing Medicaid program (except for long-term care services) and provide the same scope of benefits as for employment-based coverage. In addition to the basic benefits, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children under the age of 21 would be covered. EPSDT services do incorporate coverage of medical rehabilitation services. However, almost all existing state Medicaid plans currently provide coverage of medical rehabilitation services in a variety of community-based delivery settings for the broader eligible population.

In summary Senator Mikulski, our country has the best acute care in the world. Our commitment to rehabilitation must equal our commitment to saving lives. If rehabilitative services are not provided people will be institutionalized at a cost much greater in both financial and human terms.

Camille E. Wheeler, ACSW
President, Maryland Chapter
National Association of Social Workers

My name is Camille Wheeler, and I am President of the Maryland Chapter of the National Association of Social Workers (NASW). NASW represents 135,000 professional social workers nationwide, two-thirds of whom practice in health and mental health care settings. In Maryland our membership numbers in excess of 3500 Thank you for the opportunity to present NASW's views on legislation to improve health insurance coverage and to contain health care costs.

NASW has a longstanding history of advocating for a national health care program that can provide comprehensive health, mental health, and long-term care services to all Americans. Our association has invested considerable energy in the current debate on health care reform, and last year the Board of Directors approved the NASW National Health Care Proposal. The NASW plan would replace the more than 1500 public and private health insurance programs that currently exist with a single-payer, publicly-administered system.

The NASW plan provides coverage for comprehensive benefits. In audition to traditional hospital and outpatient primary care, the NASW plan includes: disease prevention and health promotion services; care coordination services; mental health care that is covered in the same fashion as physical health care; substance abuse services; rehabilitation services; long-term care, including home and community-based services; hospice care; prescription drugs; and dental and vision care. The NASW plan

also includes service delivery improvements, such as the use of integrated health services to enhance continuity of care and service efficiency, care coordination for individuals with chronic or multiple health problems, improved planning for health and mental health service delivery for inner city and rural populations, and screening and care coordination systems for the delivery of long-term care. A one-page summary of the NASW plan is attached to this statement.

The legislation before Congress that is most similar to the NASW plan in H.R. 1300, the Universal Health Care Act of 1991, which was introduced in the House by Representative Marty Russo and currently has 67 cosponsors. The Senate companion bill, S.2320, was recently introduced by Senators Wellstone, Metzenbaum, and Simon. Although NASW developed its own plan, the association also endorses the Russo Bill and S. 2320 because we believe that the single-payer approach provides the best response to our nation's health care crisis. A single-payer system offers the means to ensure that every American has access to high quality health, mental health, and long-term care services. And we believe that such a financing and payment system is one that the United States can afford--both now and in the future.

A single payer system is the only reform proposed thus far that adequately addresses the problems of both access and cost. Everyone would be covered under the same plan, eliminating the many tiers of private and public health care coverage that are available today. Cost containment and administrative cost savings are key elements of the single-payer approach might be opportunity to control costs through global budgeting, negotiated payment rates to providers, and efficient distribution health care resources and technology. As you are aware, the U.S. General Accounting Office (GAO) recently reported that the U.S. could achieve savings of $67 billion in the short run by shifting to a Canadian style, single-payer system. Both GAO and the Congressional Budget Office have stated that a single-payer system could save enough funds to allow universal coverage without consumer cost-sharing.

I don't know any one who does not feel vulnerable in our current system of health insurance coverage. The polls reflect that feeling of vulnerability.

. A 1990 Los Angeles Times survey found that one in six adults 18%) under age 65 reported their health benefits were reduced over the previous two-year period. The same poll also showed that Americans pay an average of 26% of their health care bills out-of-pocket, and one in six (19%) report paying more than 40% of these costs directly.

. A 1991 New York Times/CBS poll showed that one in ten Americans have at least some time stayed in a job they wanted to leave mainly because they did not want to lose health coverage. This phenomenon, known as "job lock", is most common among middle-income households.

Other polls reflect the growing sentiment among the U.S. population for change in the health care system.

. A 1988 poll conducted by Louis Harris and Associates and the Harvard School of Public Health, showed that 89% of Americans believe that the U.S. health care system requires fundamental change or complete rebuilding.

. In two surveys conducted in ten nations, it was found that Canadians were the most satisfied with their current health care system and Americans the least. The countries surveyed were the United States, England, Canada, Netherlands, Italy, West Germany, France, Sweden, Australia, and Japan.

. A 1990 Los Angeles Times poll showed that 66% of Americans would prefer the Canadian health care system over the american system. This poll replicated a 1988 poll conducted by Louis Harris and Associates, which found that 61% of Americans expressed a preference for the Canadian system. Both polls

showed that the desire for the Canadian system was strongest among middle-income Americans

. An NBC survey conducted in 1989 found that 67% of the American public favored "a comprehensive national health plan that would cover all Americans and be paid for by federal tax revenue."

Other evidence of Health Care Crisis is that

. 13 percent of the U.S. gross national product was spent on health care in 1991, up from 9.3 percent in 1980, much higher than any other advanced industrial nation which puts our businesses at a competitive disadvantage.

. In 1980 the average family spent 9 percent of its annual income on health care ($1,742); that has risen to 11.7 percent this year ($4,296).

. Maryland businesses experience a 20 percent increase in health care costs each year--to an average of $3,161 per employee.

. The State of maryland will spend about $1.186 billion on medicaid this fiscal year, up 28 percent from 2 years ago

. Most Marylanders (64.9 percent) depend on their employer for health insurance coverage.

. As the percentage spent on health care increases so does the percentage of the uninsured (about 12 percent of maryland's population, or 570,000).

. Most of the uninsured are employed (64.9 percent), are between the ages of 18 and 34. While many are poor, about a third have family incomes over $30,000 per year

. Finally, we are the only country in the world that relies on a voluntary agreement between employers and employees to provide individuals and their families with access to health care coverage.

Two years ago very few individuals or groups supported a single-payer national health program. Today, single-payer plans have been introduced in 20 states around the country and have received significant support. In Congress, .R. 1300 has the largest number of cosponsors than any other health reform proposal. In my view, this growing momentum for a single-payer system indicates political feasibility.

I would also like to briefly respond to two questions that are often raised regarding the single-payer approach--" who will pay for single-payer reform?" and "Doesn't a single-payer system presume rationing of care?"

Who will pay for the single-payer plan?

A single-payer system does not require massive dollars from new sources of revenue. What it does require, however, is a transfer in how we collect and pay for health care through the tax system. We believe we need to shift the dollars currently spent on health care--a combination of premiums, copayments, deductibles, and out-of-pocket costs now paid by American families and businesses, along with current federal and state contributions--to a more efficient and equitable system of payment.

Doesn't a single-payer system presume rationing of care?
We all know that rationing occurs now. When 37 million people are uninsured, when only 41% of those below the poverty line receive Medicaid benefits, or when 1/5 of all pregnant women do not receive prenatal care, as was the case in the 1980, there is rationing. Our two-tier health system provides inferior, limited, or no care to those who are poor, without insurance, or under-insured.

We know from data published by health analysts, the General Accounting Office, and the Office of Technology Assessment that tens of billions of dollars are currently spent on unnecessary procedures and inefficient use of health resources--dollars that can be used for needed care. We also know that there is inefficient use of hospitals. The average occupancy rate of hospitals is 65%. This means we pay an astronomical amount of fixed costs to keep these hospitals in business. Clearly, we need to consolidate some acute care hospitals, convert others into specialty hospitals, and turn other into other needed facilities, such as rehabilitation centers or community outpatient centers. Again, this will save money and allow for better, cost-efficient care for everyone.

More equitable distribution and efficient use of health care resources, the establishment of practice guidelines, better consumer education, and expanded review of the quality and cost of care will enable this system to meet the health needs of most Americans. While some rationing may occur, we believe that it will be far less than we have now. We also believe that people will be willing to accept some limitations if they have access to good, quality health care when they need it.

Americans are spending increasingly more for health care and receiving less than citizens of most of other countries in the industrialized world. On October 2 the Department of Health and Human Services reported that the nation's health spending reached a record $666.2 billion in 1990. According to the Democratic Study Group's special report on health care in May, health care in the U.S. is the most expensive in the world. The DSG special report indicates that the cost of U.S. health care is not due to a greater use of health services in the U.S. than in other Countries, nor does it result in higher rankings on the basic indicators of health status as compared To other industrialized nations.

Our association policies support the provision of health care as a basic right, not a commodity. Accordingly, we believe that the goal of health care reform ought to be the assurance that quality health, mental health, and long-term care services are available to all Americans. NASW is convinced that a single-payer national health care program is the means to accomplish this goal.

NASW National Health Care Plan

In response to our country's severe health care crisis, the NASW developed a National Health Care [illegible] plan that fundamentally restructures our costly and inefficient health system and provides every American with comprehensive health and mental health services, including long-term care.

The basic components of the NHC Plan include:

- A single-payer health system administered by the states under federal guidelines.
- Universal access for all U.S. residents regardless of race, national origin, income, religion, age, sex, marital preference, language, or geographical residence.
- Freedom to choose from among any of the participating public and private providers.
- Expansion of public health functions for disease prevention and health promotion.
- Less reimbursement services to assure appropriate and cost-efficient health care.
- No cost-sharing, except for a modest user and board fee based on income for nursing home care. The plan allows limited cost-sharing based on income, if necessary, to control excess utilization.
- Global budgeting for states with expenditure targets by category of services.
- Global budgeting for hospitals and prospective payment systems for other health facilities, with state regulated [illegible] for capital expansion and purchase of costly specialized equipment.

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TESTIMONY BEFORE THE UNITED STATES SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES RELATING TO NATIONAL HEALTHCARE REFORM

Presented By: Michael G. Bronfein, CPA
President, and Chief Executive Officer
NeighborCare Pharmacies

April 23, 1992

I. Background:

Over the past 10 years there has been an increase in the use of 3rd party prescription cards for the payment of prescription services. Initially these cards provided patients indemnified pharmacy services as part of their indemnified health care plan. Generally the cost of the prescription, to the patients, was included in the insurers plan with the patient paying a co-pay of $3.00 to $5.00 per prescription. The pharmacy charged the insurer the same price that it charged to the general public. The price generally has two components; an ingredient price and dispensing fee. The ingredient price was based upon the average wholesale price (AWP) of the drug (as published by Medispan, Inc. or First Data Bank) plus a dispensing fee ranging from $2.00 to $4.00 per prescription. Generally the average plan would allow for reimbursement to the pharmacy at AWP plus a $3.00 dispensing fee.

Given the relatively low cost of prescription drugs until 5 years ago this pricing mechanism provided a fair return to the pharmacy owner.

As drug ingredient costs began to rise, 3rd party payers searched for methods to limit their exposure. They did this by increasing the co-pays which their insureds paid at the time of purchase and by eliminating certain drugs from the benefit program.

The next evolution occurred when certain Health Maintenance Organizations (HMO's) began to offer a reimbursement rate equal to (AWP - 10%) plus a dispensing fee, to pharmacies, in exchange for a "closed" distribution network. The pricing theory promoted by the HMO's was that a closed system would limit the amount of administrative costs incurred and ingredient expense and in exchange the pharmacy would enjoy a disproportionate market share and limited marketing costs.

Unfortunately what started as a very small part of the pharmacy industry began to permeate the entire industry. The notion of reduced AWP's was highly promoted by 3rd party administrators. Third party administrators often suggested that the marginal cost of filling one more prescription is very low; therefore, a low 3rd party dispensing fee with reduced AWP should be sufficient to cover the marginal cost of filling that additional 3rd party prescription.

This argument is a misuse of the concept of marginal costs. First it should be pointed out that a 3rd party prescription may not be an additional prescription but rather a different payment mechanism for a prescription that would have been dispensed anyway and paid for by the patient. Often 3rd party prescriptions are not new or additional prescriptions for the pharmacy but are merely existing prescriptions paid for by an alternative mechanism. Secondly, the concept of marginal costs can not be used to justify reimbursement for all 3rd party prescriptions Currently, direct reimbursement by 3rd party comprises approximately 40% of all prescriptions. **Marginal cost pricing of 3rd party prescription dispensing would mean that private pay prescriptions would have to pay 100% of the fixed costs from all prescriptions in addition to the marginal costs of their own prescriptions.** This practice results in an ever larger shifting of costs from 3rd party to private pay customers as the percentage of 3rd party prescriptions in a pharmacy grows. With such a large volume, 3rd party business cannot be considered marginal any longer. Therefore, it is imperative that 3rd party prescriptions be viewed in terms of fully absorbed costs or total costs versus marginal costs.

Finally, in the Fall of 1991 the State of Maryland in an effort to reduce it's employee benefit costs decided to reduce the reimbursement on the ingredient portion of its prescription plans from AWP to AWP - 8%. Concurrently the dispensing fee paid to the pharmacists was increased from $3.00 to $3.75. **This event was significant in that it set a precedent which was soon followed by virtually every other 3rd party payer including HMO's, Private Employers and Insurance Companies. In fact, as of November, 1991, 26 various plans provided notice to pharmacies that they were unilaterally and arbitrarily reducing their reimbursement rates.**

Consequently, what was once promoted as marginal pricing to a small population of potential patients has become the standard among virtually all 3rd parties, except Maryland Medicaid. It is curious to note that at the present time the Maryland Medicaid Pharmacy Program provides the highest level of reimbursement of all major third party plans in the state. This is sad testimony to the abusive reimbursement practices which have been imposed upon the pharmacy community by HMO's and third party administrators.

II. What Are The Issues Relating Cost Shifting via Prescription Drug Plans

* **Equality** - all patients deserve have the right, regardless of payer, to pay the same amount for their prescription purchases. Presently, the unindemnified purchaser of prescription services is paying a higher proportion of costs due to the abusive practices of the indemnity providers.

* **Fairness** - Pharmacies provide an important service to the communities they serve. Both chain and independent pharmacies are entitled to make a fair and reasonable return on their investment.

* **Jobs** - Current reimbursement rates by 3rd parties are below the cost of operations. If this trend continues Pharmacies both Chain and Independent will be forced to further reduce costs by eliminating jobs.

* **Survival** - Action must be taken to level the playing field for the unindemnified patient; which constitutes approximately 60% of the population, and the operators of pharmacies. **Pharmacies can not make up their incremental losses on volume. Focus must be directed to affecting the behaviors which influence cost versus reacting to symtoms of those behaviors.**

III. Economic Impact:

In today's world of spiraling costs and poor economic conditions, we are all extremely sensitive to the perception of any activity which would increase costs. **However, eliminating unfair cost shifting is not about increasing costs but rather about re-allocating the costs so that all parties receiving care share the burden equally.** Moreover, a study by the RAND Corporation found that when people were responsible for a greater percentage of their health care costs and understood those costs they became much more responsible in the use of their health care benefits. Perhaps, legislative actions which influences patient behavior will make the indemnified patient more aware of the true costs of prescription drug therapy and will therefore sensitize them to becoming more involved in how their funds, either directly or indirectly, are spent. Moreover, the population which can least afford health care, the unindemnified population, is presently being burdened by subsidizing large insurance companies and HMO's. This is an unfortunate fact of economic life which no pharmacy operator can deny.

If a pharmacy needs a dollar of gross margin to pay its expenses and previously received 50 cents from the indemnified and 50 cents from the unindemnified population, they must continue to receive that compensation even if the compensation per group shifts. Therefore, if the indemnified group is only willing to pay 45 cents then in turn the unindemnified group must pay 55 cents. If not, the pharmacy operator can not survive.

Attached is the 1991 Lilly Digest. The Lilly Digest is an annual study performed by Eli Lilly and Company of the pharmacy industry in the United States. It is a survey which has been conducted for over 59 years. Its mission is to provide, and I quote, "a compressive reference source to be used by drug store management to improve profitability."

This year's Lilly's Digest indicates some very distribing trends:

* The cost of sales increased in 1990, resulting in a gross profit margin decrease to 30% of total sales, the lowest in the history of the Lilly Digest. Secondly, net profit, before tax, was 2.9% of sales down from the previous year's 3.1%.

* Managers may attempt to profit in light of a declining gross margin percent by raising prices when competition allows (to cash paying customers) or by eliminating unprofitable 3rd party plans.

Other highlights from the Lilly Digest:

1. Table Seven - Page 22 - Table Seven indicates that as the percentage of prescription sales to total sales increases, the gross profit margin for the particular operation decreases.

* **Since 1981 gross profit margins have decreased from 34.3% of sales to 30% of sales in 1990."**

As this disturbing trend in pharmacy evolved another trend has evolved in the managed care industry. Its profitability has improved. According to an update edition of the Marion Merrell Dow Managed Care Digest "throughout the industry, HMO profitability improved very significantly during 1990.

Attached are excerpts from the Marion Merrell Dow Managed Care Digest Update 1991. Two interesting facts are articulated throughout the study. First, HMO's as a group enjoyed significant improvement in profitability in 1990. Secondly, the Digest characterizes the two most important operating costs for HMO's as in-patient (hospital) expenses and physician costs. Nowhere in the report does it suggest the cost of pharmaceutical care is a significant issue with respect to profitability of the nations

HMO's. Moreover, in examining the profit and loss statements which are outlined on pages 13 and 19 of the report, pharmaceutical costs are not highlighted. This could lead one to conclude that HMO's do not truly view drug costs and containment thereof, as a critical issue. In fact, the Digest states, "mature HMO's experience an average of 7% increase in the cost of in-patient care in 1990 but that was out-paced by 17% increase in the cost of physician care for the year." It goes on to state that total administrative expenses rose 29% during 1990 for mature HMO's An amount far in excess of the price increases imposed by drug manufacturers.

CONCLUSION: It seems incongruent that the party least able to control drug costs (i.e. the pharmacy) is being imposed upon unilaterally by 3rd party providers to do just that. Since the pharmacist does not prescribe the drug he or she has very little control over the cost of drug therapy. Almost universally, pharmacists today, are recommending the use of generic equivalents in order to contain costs. Clearly this is the type of responsibility a pharmacist should have; however, effective drug cost containment can only be accomplished through prospective and concurrent drug utilization programs which are promoted by the providers, followed by the physicians and patients, and participated in by the pharmacies. Through a cooperative effort, drug costs can be contained. This effort should not focus in on the most expedient methodology, i.e., reducing the reimbursement paid to the pharmacy. It should be achieved through a pro-active drug ulitization process. Through greater awareness of drug costs, patients and physicians can begin to take greater responsibility and thereby reduce the overall costs of prescription drug therapy.

DEFINITION OF TERMS

The following terms are hereby defined and utilized in Exhibits I, II, AND III.

AWP =	**AVERAGE WHOLESALE PRICE**	
COST =	**AWP - 16%**	
DISPENSING FEE =	**THE AMOUNT OF FEE PAID FOR PROFESSIONAL SERVICES.**	
PHARMACY OPERATING COSTS (As a Percent of Sales)	**HIGH**	**- 31.7%**
	LOW	**- 24.8%**
	AVERAGE	**- 27.1%**

Note: 1) According to a report issued by the Inspector General of the Health Care Financing Adminsitration (HCFA) the average difference between Average Wholesale Price and true acquisition costs by pharmacies of prescription durgs is 15.9%. (Report: A-06-89-00037).

Therefore, to arrive at the cost of a prescription drug in the examples given, the average wholesale price has been reduced by 16% to determine the true acquisition cost.

2) The pharmacy operating costs are extracted from the 1991 "Lilly Digest" - published by Eli Lilly and Company.

EXHIBIT I

ANALYSIS OF LOST GROSS PROFIT MARGIN
DUE TO UNILATERAL REDUCTION IN REIMBURSEMENT RATES

EXAMPLE: State of Maryland Employee Drug Program

A) Prior to Unilateral Reimbursement Change:

$25.00 = Average Retail Selling Price
$22.00 = AWP

Calculation of Prescription Cost:

(AWP x 84%) = ($22.00 x 84%) = $18.48

$25.00 = Average Retail Selling Price
$18.48 = Cost
$ 6.52 = Gross Margin
26.08% = Gross Margin Percent

B) After Unilateral Reimbursement Change:

(AWP - 8% + $3.75) = Adjusted Selling Price
($22.00 - $1.76 + $3.75) = $23.99

Calculation of Adjusted Gross Margin:

$23.99 = Adjusted Selling Price
$18.48 = Cost
$ 5.51 = Gross Margin
22.96% = Gross Margin Percent

Note: According to the 1991 "Lilly Digest" the average cost of operating a retail pharmacy in the United States is 27.8% of sales with a range of 31.7% on the high end and 24.8% on the low end.

Therefore, the current reimbursement rate from the State of Maryland Employee Drug Program is below the cost of operations and thereby contributes to cost shifting by the Pharmacy in order for the pharmacy to stay in business.

The State of Maryland Employee Drug Program allows the pharmacy to charge the incremental difference, to the patient, between its' Usual and Customary selling price and the plan reimbursement, when necessary. This is currently the only plan which allows this option to the pharmacy.

EXHIBIT II

ANALYSIS OF LOST GROSS PROFIT MARGIN
DUE TO UNILATERAL REDUCTION IN REIMBURSEMENT RATES

EXAMPLE: MD - IPA Prescription Plan

A) Prior to Unilateral Reimbursement Change:

$22.53 = Average Retail Selling Price
$ 2.00 = Dispensing Fee
$20.53 = AWP

Calculation of Prescription Cost:

(AWP x .84%) = ($20.53 x .84%) = $17.24

$22.53 = Average Retail Selling Price
$17.24 = Cost
$ 5.29 = Gross Margin
23.48% = Gross Margin Percent

B) After Unilateral Reimbursement Change:

($20.53 x .90%) = $18.48 + $2.50 = $20.98

Calculation of Adjusted Gross Margin:

$20.98 = Adjusted Selling Price
$17.24 = Cost
$ 3.74 = Gross Margin
17.82% = Gross Margin Percent

As the above indicates, if the Pharmacy is not allowed to charge the difference between MD-IPA's reimbursement and its' Usual and Customary price the Pharmacy would loose approximately 7.0% (17.8% - 24.8%) per prescription dispensed or $1.55 per prescription. This amount must be added to the cost of a cash paying customer, resulting in a cash price of $24.08. ($22.53 + $1.55).

Therefore, MD-IPA is forcing the Pharmacy to create a gap of $3.10 ($24.08 - $20.98) or a 15% higher price for the cash paying customer relative to the MD-IPA covered patient.

EXHIBIT III

ANALYSIS OF LOST GROSS PROFIT MARGIN
DUE TO UNILATERAL REDUCTION IN REIMBURSEMENT RATES

EXAMPLE: PCS - Prescription Plan

A) Prior to Unilateral Reimbursement Change:

$29.44 = Average Retail Selling Price
$ 3.30 = Average Dispensing Fee
$26.14 = AWP

Calculation of Prescription Cost:

(AWP x 84%) = ($26.44 x .84%) = $22.20

$29.44 = Average Retail Selling Price
$22.20 = Cost
$ 7.24 = Gross Margin
$24.59% = Gross Margin Percent

B) **After Unilateral Reimbursement Change:**

($26.14 - 10%) + $3.75 = $26.83

Calculation of Adjusted Gross Margin:

$26.83	= Adjusted Selling Price
$22.20	= Cost
$ 4.63	= Gross Margin
$17.25%	= Gross Margin Percent

Therefore, the Pharmacy will lose approximately 7.55% on each sale to PCS (17.25% - 24.8%) or $2.61 per prescription.

Therefore, PCS is forcing the Pharmacy to create an average gap of $5.22 ($32.05 - $26.83) between the cash paying customer and the PCS covered patient.

MAMSI M.D.IPA The Quality Care Health Plan MAPSI alliance OPTIMUM CHOICE

February 20, 1992

Dear Participating Pharmacy:

M.D.IPA and Optimum Choice, Inc. (OCI) Health Plans have experienced significant membership growth since 1990. This growth has resulted in over 420,000 members. In order to manage the increased pharmacy activity that our continued membership growth will generate, M.D.IPA and OCI have entered into an agreement with Diversified Pharmaceutical Services, Inc. (DPS). As a result of this new relationship, the terms of the M.D.IPA and OCI pharmacy contracts, as well as the on-line processing system, are being modified.

PHARMACY CONTRACTS

Effective March 16, 1992, the terms of the agreement for participating pharmacies will change. Under the new agreement, reimbursement will be provided at the lesser of 90% of the Average Wholesale Price (AWP), the requested amount, or according to a Maximum Allowable Cost (MAC). The dispense fee will be $2.50 per prescription (for both brand and generic products).

Two copies of each of the M.D.IPA and OCI contracts are enclosed. (These agreements are similar, except language has been incorporated in the M.D.IPA agreement related to a Preferred Provider Arrangement, which may in the future be added as a benefit to the Pharmacy to offer services to Members of this program.) Pharmacies should sign and return the four contracts no later than Friday, March 6. Once the contracts have been countersigned, both an M.D.IPA and OCI contract will be returned to you.

Please note these contracts will supercede the contract you previously signed with M.D.IPA and OCI. If you do not wish to participate under the terms of the new agreement, please consider this letter as a ninety-day notice of termination, effective May 25, 1992, to your prior contract. Pharmacies that have not returned the signed contracts by the above deadline will be considered to have exercised their option of termination.

ON-LINE CLAIMS PROCESSING PROCEDURES

All claims with dates of service through March 15, 1991 must be processed by March 18, 1992 using National Data Corporation (NDC) BIN numbers. After March 18th, claims will be rejected through NDC with the message "Payor Unavailable". Please contact your software vendor to obtain the BIN number to be used for claims processed through DPS with dates of service March 16, 1992 and thereafter.

We look forward to your continued participation. If you have any questions, please contact Beth Landry, Professional Services Manager at (301) 294-5121, Shirley Grubbs, Professional Services Supervisor at (301) 294-5125, or Paula Groff, Professional Services Supervisor at (301) 294-5015 or (800) 342-6141.

Sincerely,

Gloria Pilgrim

Gloria Pilgrim
Director of Pharmacy

4 Taft Court • Rockville, MD 20850 • (301) 762-8205 • Fax: (301) 762-0658

NeighborCare™
PHARMACIES

MEMORANDUM

January 1, 1992

TO: STATE OF MARYLAND EMPLOYEES AND RETIREES

RE: PRESCRIPTION DRUG BENEFIT PROGRAM

Over the years, we at NeighborCare Pharmacies have prided ourselves in providing you and your family with the finest healthcare services available. We believe you chose NeighborCare as your pharmacy because you wanted your family to receive the best healthcare service available.

In the past, your prescription drug program has provided a reasonable reimbursement rate to NeighborCare Pharmacies to allow it to provide you with "Care you can depend on" while allowing NeighborCare to make a fair return.

Effective January 1, 1992, the State of Maryland changed your prescription drug program. They did so by creating a two tiered reimbursement system for pharmacies. This change resulted in two types of providers: Select and Non-Select.

Information you received from the State incorrectly characterized the difference between the two types of providers. Simply stated, Select pharmacies are those which have chosen to accept as payment in full, a lower reimbursement rate. Non-Select pharmacies are those which have chosen not to accept the lower reimbursement rate.

What does this mean to you, our valued customer? Simply stated it means you will pay a slightly higher co-pay when you utilize a Non-Select pharmacy. The discount the State chose to take is 8% of the ingredient cost of the prescription or $.08 for every $1.00.

To illustrate, a prescription with a selling price of $13.75 will result in an increased co-pay to you of $.80; a prescription with a selling price of $23.75 will result in an increased co-pay to you of $1.60; and a prescription with a selling price of $33.75 will result in an increased co-pay to you of $2.40. Obviously, these are examples, your co-pay will be a function of the selling price of the prescription dispensed. NeighborCare's ***CareFile*** computer system is linked electronically to the State of Maryland's computer and will determine the exact amount of the co-pay at the time the prescription is filled.

In all candor, we at NeighborCare are not pleased to be forced to take this action; however, a quality service cannot be produced for the price of a commodity. We have attempted to persuade the State to seek alternative means for reducing cost. We believe that the State has chosen the wrong party to utilize for cost containment. The Pharmacy does not influence how much or what type of drug you take and therefore has very little ability to influence cost. Unfortunately, the Pharmacy is the easiest target and therefore the one chosen by the State.

What can you do? Call the State Employment Office and protest!! Utilization review and preview are the most effective methods for cost containment, not reduction in reimbursement rates paid to your pharmacy.

We at NeighborCare truly appreciate your business and very much want to continue to be part of your healthcare team. Finally, it is important to note that this measure merely asks your employer to pay the same amount for your prescription services as those who do not have a prescription card, but pay cash. We believe consistent pricing, regardless of payor, is a fair policy, and the right thing to do. We believe you will agree.

Should you have any questions about these changes, please see your NeighborCare Pharmacist or call us at 752-CARE.

THANK YOU.

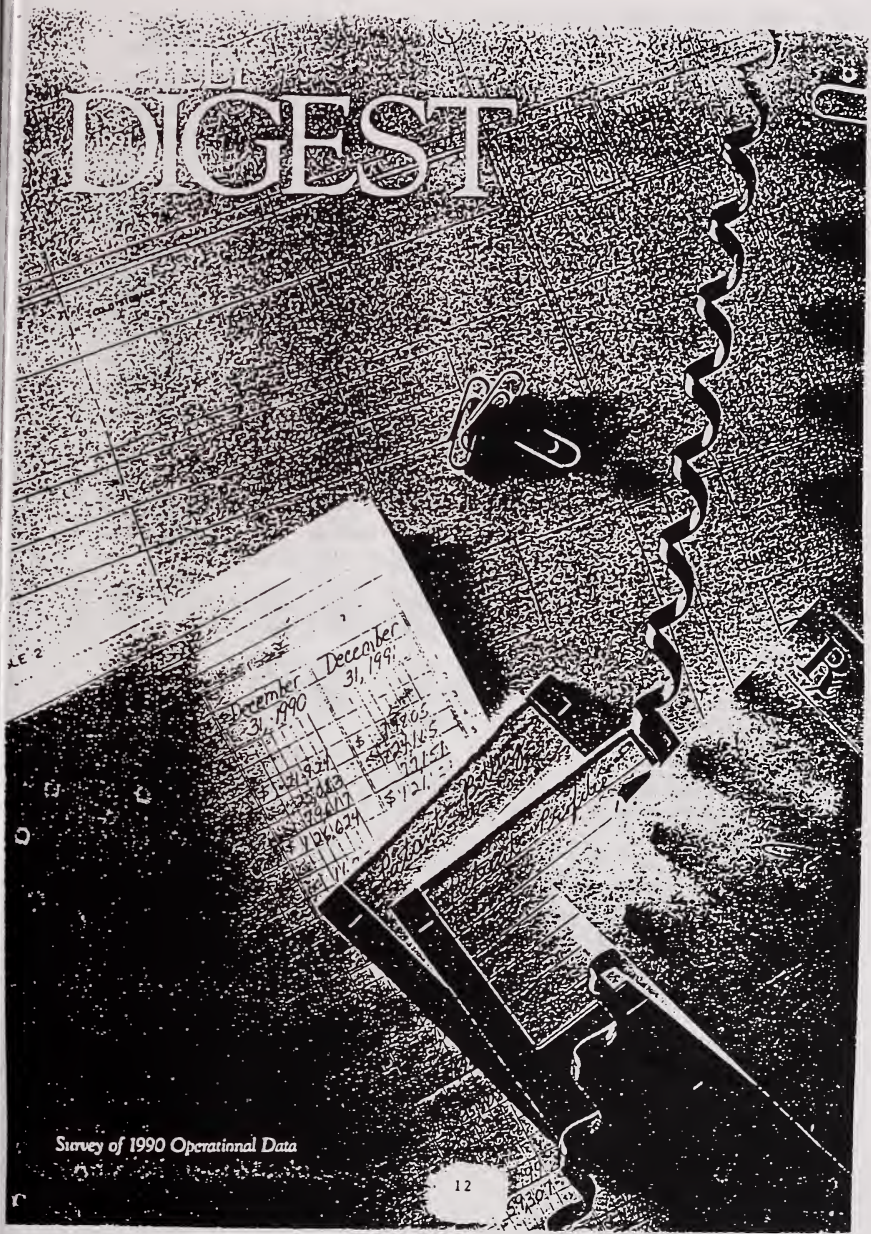
DIGEST
December 31, 1990
December 31, 199
Survey of 1990 Operational Data
12

Table 1 *Current trends in pharmacy operations*

Averages per Pharmacy	1990 (1,575 Pharmacies)		1989 (1,684 Pharmacies)		Amount and Percent of Change
Sales					
Prescription	$671,505—	73.1%	$584,539—	72.1%	+$ 86,966—14.9%
Other	246,813—	26.9%	226,002—	27.9%	+$ 20,811— 9.2%
Total sales	$918,318—	100.0%	$810,541—	100.0%	+$107,777—13.3%
Cost of goods sold	642,785—	70.0%	558,124—	68.9%	+$ 84,661—15.2%
Gross margin	$275,533—	30.0%	$252,417—	31.1%	+$ 23,116— 9.2%
Expenses					
Proprietor's salary	$ 52,701—	5.7%	$ 48,125—	5.9%	+$ 4,576— 9.5%
Employees' wages	82,158—	8.9%	75,298—	9.3%	+$ 6,860— 9.1%
Rent	20,643—	2.2%	18,798—	2.3%	+$ 1,845— 9.8%
Utilities	8,233—	0.9%	7,726—	1.0%	+$ 507— 6.6%
Accounting, legal, and other professional fees	3,782—	0.4%	3,403—	0.4%	+$ 379—11.1%
Taxes (except on buildings, income, and profit) and licenses	12,412—	1.4%	11,196—	1.4%	+$ 1,216—10.9%
Insurance (except on buildings)	9,705—	1.1%	8,686—	1.1%	+$ 1,019—11.7%
Interest paid	5,961—	0.6%	5,414—	0.7%	+$ 547—10.1%
Computer	3,044—	0.3%	3,206—	0.4%	−$ 162— 5.1%
Depreciation (except on buildings)	7,441—	0.8%	7,655—	0.9%	−$ 214— 2.8%
Miscellaneous	42,785—	4.7%	38,018—	4.7%	+$ 4,767—12.5%
Total expenses	$248,865—	27.1%	$227,525—	28.1%	+$ 21,340— 9.4%
Net profit (before taxes)	$ 26,668—	2.9%	$ 24,892—	3.1%	+$ 1,776— 7.1%
Proprietor's withdrawals	52,701—	5.7%	48,125—	5.9%	+$ 4,576— 9.5%
Total income of self-employed proprietor (before taxes on income and profits)	$ 79,369—	8.6%	$ 73,017—	9.0%	+$ 6,352— 8.7%
Value of inventory at cost and as a percent of sales					
Prescription	$ 66,670—	9.9%	$ 59,469—	10.2%	+$ 7,201—12.1%
Other	51,095—	20.7%	47,835—	21.2%	+$ 3,260— 6.8%
Total value	$117,765—	12.8%	$107,304—	13.2%	+$ 10,461— 9.7%
Annual rate of inventory turnover	5.6 times		5.4 times		
Size of area and sales per square foot*	sq. ft.		sq. ft.		sq. ft.
Prescription	479	$401.37	460	$1,270.74	+ 19— 4.1%
Other	2,359	$104.33	2,333	$ 96.87	+ 26— 1.1%
Total size	2,838	$323.22	2,793	$ 290.20	+ 45— 1.6%
Number of prescriptions dispensed					
New	16,832—	51.1%	16,510—	51.9%	+ 322— 2.0%
Renewed	16,100—	48.9%	15,310—	48.1%	+ 790— 5.2%
Total prescriptions dispensed	32,932—	100.0%	31,820—	100.0%	+ 1,112— 3.5%
Prescription charge	$20.39		$18.37		+$ 2.02—11.0%
Number of hours per week					
Pharmacy was open	60 hours		60 hours		0
Worked by proprietor	55 hours		55 hours		0
Worked by employed pharmacist(s)	28 hours		26 hours		2
Sales and prescription activity per pharmacy hour open					
Prescription sales	$215.23		$187.35		+$ 27.88—14.9%
Other sales	$ 79.11		$ 72.44		+$ 6.67— 9.2%
Prescriptions dispensed	10.6		10.2		+ 0.4 — 3.9%
Percent of total prescriptions covered by					
Medicaid	18.1%		16.8%		
Other third party	22.3%		22.3%		

*Based on averages of pharmacies that reported all data

NOTE: These national averages are presented to give a composite picture of the average Lilly Digest pharmacy. Comparisons for analysis should be based on the operations of pharmacies of comparable sales and prescription volume that appear in 1 of the 30 arrangements in "The Heart of the Lilly Digest" (pages 13-24).

Sales
$1,000,000-
$1,500,000

TABLE E

Averages per Pharmacy	Total Sales $1,000,000–$1,500,000 Under 100 Prescriptions Daily (57 Pharmacies)	100 to 125 Prescriptions Daily (83 Pharmacies)	125 to 150 Prescriptions Daily (88 Pharmacies)	Over 150 Prescriptions Daily (99 Pharmacies)
Sales				
Prescription	$ 564,710— 49.8%	$ 796,866— 66.2%	$ 912,658— 77.1%	$1,031,864— 82.4%
Other	569,421— 50.2%	407,583— 33.8%	271,093— 22.9%	218,753— 17.6%
Total sales	$1,134,131—100.0%	$1,204,448—100.0%	$1,183,751—100.0%	$1,251,817—100.0%
Cost of goods sold	785,106— 69.2%	848,673— 70.5%	831,782— 70.3%	888,572— 71.0%
Gross margin	$ 349,025— 30.8%	$ 355,776— 29.5%	$ 351,969— 29.7%	$ 363,046— 29.0%
Expenses				
Proprietor's or manager's salary	$ 58,622— 5.2%	$ 59,744— 5.0%	$ 66,264— 5.6%	$ 62,016— 5.0%
Employees' wages	116,243— 10.2%	114,214— 9.5%	109,604— 9.3%	114,561— 9.2%
Rent	34,087— 3.0%	32,142— 2.7%	22,705— 1.9%	20,959— 1.7%
Utilities	11,033— 1.0%	12,224— 1.0%	9,803— 0.8%	9,411— 0.8%
Accounting, legal, and other professional fees	4,019— 0.4%	4,887— 0.4%	4,164— 0.4%	5,207— 0.4%
Taxes (except on buildings, income, and profit) and licenses	16,003— 1.4%	16,873— 1.4%	16,318— 1.4%	16,728— 1.3%
Insurance (except on buildings)	12,198— 1.1%	12,349— 1.0%	11,637— 1.0%	13,440— 1.1%
Interest paid	7,429— 0.7%	8,821— 0.7%	9,202— 0.8%	9,063— 0.8%
Computer	3,068— 0.3%	3,173— 0.3%	3,417— 0.3%	4,881— 0.4%
Depreciation (except on buildings)	10,498— 0.9%	8,307— 0.7%	14,178— 1.2%	8,606— 0.7%
Miscellaneous	54,546— 4.8%	53,401— 4.4%	53,981— 4.6%	56,069— 4.5%
	10.6%	9.9%	10.7%	9.7%
Total expenses	$ 326,689— 28.8%	$ 325,345— 27.0%	$ 317,390— 26.8%	$ 317,656— 25.4%
Net profit (before taxes)	$ 22,336— 1.9%	$ 30,431— 2.5%	$ 34,569— 2.9%	$ 45,389— 3.6%
Add proprietor's withdrawals	58,622— 5.2%	59,744— 5.0%	66,264— 5.6%	62,016— 5.0%
Total income of self-employed proprietor (before taxes on income and profits)	$ 80,958— 7.1%	$ 90,175— 7.5%	$ 100,833— 8.5%	$ 107,404— 8.6%
Value of inventory at cost and as a percent of sales				
Prescription	$ 58,705— 10.4%	$ 84,023— 10.5%	$ 84,772— 9.3%	$ 90,823— 8.8%
Other	127,014— 22.3%	88,025— 21.6%	61,918— 22.8%	36,408— 16.6%
Total value	$ 185,719— 16.4%	$ 172,048— 14.3%	$ 146,690— 12.4%	$ 127,231— 10.2%
Annual rate of turnover of inventory	4.3 times	5.1 times	5.8 times	7.1 times
Size of area and sales per square foot*	sq. ft.	sq. ft.	sq. ft.	sq. ft.
Prescription	608 $ 934.12	462 $1,725.80	542 $1,683.87	581 $1,783.06
Other	4,348 129.96	4,172 95.84	2,735 100.37	1,831 119.83
Total size	4,956 $ 228.81	4,634 $ 259.89	3,277 $ 362.90	2,412 $ 520.87
Number of prescriptions dispensed				
New	13,435— 54.5%	18,601— 52.4%	21,472— 50.2%	30,025— 53.3%
Renewed	11,238— 45.5%	16,870— 47.6%	21,292— 49.8%	26,273— 46.7%
Total prescriptions dispensed	24,673—100.0%	35,471—100.0%	42,764—100.0%	56,298—100.0%
Prescription charge	$22.89	$22.47	$21.34	$18.33
Number of hours per week				
Pharmacy was open	67 hours	67 hours	64 hours	64 hours
Worked by proprietor	57 hours	56 hours	56 hours	67 hours
Worked by employed pharmacist(s)	36 hours	40 hours	38 hours	41 hours
Percent of total prescriptions covered by:				
Medicaid	18.3%	14.0%	17.2%	22.8%
Other third party	22.3%	30.1%	21.8%	22.5%

*Based on averages of pharmacies that reported all data

Sales Over $1,500,000

Total Sales Over $1,500,000

TABLE F

Averages per Pharmacy	Under 150 Prescriptions Daily (39 Pharmacies)		150 to 200 Prescriptions Daily (64 Pharmacies)		Over 200 Prescriptions Daily (105 Pharmacies)	
Sales						
Prescription	$ 952,713	52.1%	$1,196,289	62.9%	$1,792,149	71.7%
Other	876,287	47.9%	704,117	37.1%	706,118	28.3%
Total sales	$1,829,000	100.0%	$1,900,406	100.0%	$2,498,267	100.0%
Cost of goods sold	1,257,369	68.7%	1,347,988	70.9%	1,766,991	70.7%
Gross margin	$ 571,631	31.3%	$ 552,418	29.1%	$ 731,276	29.3%
Expenses						
Proprietor's or manager's salary	$ 69,888	3.8%	$ 69,723	3.7%	$ 94,263	3.8%
Employees' wages	216,917	11.9%	203,807	10.7%	268,125	10.7%
Rent	46,019	2.5%	44,795	2.4%	44,931	1.8%
Utilities	16,152	0.9%	15,107	0.8%	17,851	0.7%
Accounting, legal, and other professional fees	5,755	0.3%	8,170	0.4%	9,235	0.4%
Taxes (except on buildings, income, and profit) and licenses	24,535	1.3%	26,356	1.4%	32,148	1.3%
Insurance (except on buildings)	22,686	1.2%	20,819	1.1%	24,752	1.0%
Interest paid	14,599	0.8%	13,211	0.7%	16,009	0.6%
Computer	5,393	0.3%	4,580	0.2%	7,130	0.3%
Depreciation (except on buildings)	14,792	0.8%	10,922	0.6%	18,210	0.7%
Miscellaneous	87,610	4.8%	88,299	4.6%	111,336	4.5%
		10.4%		8.8%		9.5%
Total expenses	$ 524,346	28.7%	$ 505,589	26.6%	$ 643,990	25.8%
Net profit (before taxes)	$ 47,285	2.6%	$ 46,829	2.4%	$ 87,286	3.5%
Add proprietor's withdrawals	69,888	3.8%	69,723	3.7%	94,263	3.8%
Total income of self-employed proprietor (before taxes on income and profits)	$ 117,173	6.4%	$ 116,552	6.1%	$ 181,549	7.3%
Value of inventory at cost and as a percent of sales						
Prescription	$ 90,734	9.5%	$ 108,048	9.0%	$ 151,851	8.5%
Other	158,089	18.0%	124,711	17.7%	122,653	17.4%
Total value	$ 248,823	13.6%	$ 232,759	12.2%	$ 274,504	11.0%
Annual rate of turnover of inventory		5.1 times		5.9 times		6.5 times
Size of area and sales per square foot*	sq. ft.		sq. ft.		sq. ft.	
Prescription	464	$2,101.12	506	$2,378.46	744	$2,431.87
Other	5,547	153.14	4,497	156.03	3,855	188.26
Total size	6,011	$ 303.60	5,003	$ 380.58	4,599	$ 451.36
Number of prescriptions dispensed						
New	19,392	55.2%	29,607	54.3%	41,767	45.7%
Renewed	15,724	44.8%	24,940	45.7%	49,568	54.3%
Total prescriptions dispensed	35,116	100.0%	54,547	100.0%	91,335	100.0%
Prescription charge		$27.13		$21.93		$19.62
Number of hours per week						
Pharmacy was open		72 hours		74 hours		72 hours
Worked by proprietor		71 hours		61 hours		74 hours
Worked by employed pharmacist(s)		64 hours		65 hours		64 hours
Percent of total prescriptions covered by:						
Medicaid		10.1%		14.7%		18.6%
Other third party		30.6%		29.3%		25.5%

*Based on averages of pharmacies that reported all data

CONCLUSION

Stores that reported low (2% to 15%) and high (55% to 99%) third-party prescription volume as a percent of total prescriptions are shown in Table 17. Pharmacies with a high volume of third-party prescriptions reported lower gross margin and total income to proprietor as a percent of total sales. These operations also reported a lower average prescription charge. It is interesting to observe that high third-party activity pharmacies reported only a slightly lower net profit as a percent of total sales than did low third-party activity operations. This is in contrast to the previous year when high third-party stores reported the same net profit as the low third-party pharmacies.

For 1990 operating data, a new record was established for total sales. Gross margin as a percent of sales was the lowest in the history of the LILLY DIGEST, but gross margin dollars were the highest ever recorded in the DIGEST. The average prescription price was $20.39. From the data received, it is not possible to determine if this increase is the result of retail price increases and/or growth in days of therapy dispensed per prescription alone.

The objective of the first LILLY DIGEST, which was reflective of the 1932 operational results of 271 pharmacies, was to provide authentic and useful data on retail pharmacy operations so that owners, managers, and their financial advisors could evaluate individual operations and, perhaps, be more successful in their business endeavors. This objective has remained unchanged through the years.

Eli Lilly and Company will provide a free analysis of any independent retail pharmacy's operation. The form on pages 37 and 38 may be used to take advantage of this confidential service.

Table 17 LILLY DIGEST *averages of selected operating statistics*

Averages per Pharmacy	Selected Stores, Low Third-Party Activity (107 Pharmacies)	Selected Stores, High Third-Party Activity (233 Pharmacies)
Sales		
Prescription	$614,948— 74.4%	$ 740,999— 72.0%
Other	211,143— 25.6%	287,962— 28.0%
Total sales	$826,091—100.0%	$1,028,961—100.0%
Cost of goods sold	$577,293— 69.9%	$ 727,163— 70.7%
Gross margin	$248,798— 30.1%	$ 301,798— 29.3%
Expenses		
Proprietor's or manager's salary	$ 46,358— 5.6%	$ 54,260— 5.3%
Employees' wages	74,099— 9.0%	92,611— 9.0%
Rent	19,696— 2.4%	22,681— 2.2%
Miscellaneous operating expenses	32,376— 3.9%	42,546— 4.1%
Total expenses	$218,497— 26.5%	$ 264,736— 25.7%
Net profit (before taxes)	$ 30,301— 3.7%	$ 37,062— 3.6%
Add proprietor's withdrawal	46,358— 5.6%	54,260— 5.3%
Total income of self-employed proprietor (before taxes on income and profit)	$ 76,659— 9.3%	$ 91,322— 8.9%
Number of prescriptions dispensed		
New	13,951— 46.9%	20,196— 55.5%
Renewed	15,817— 53.1%	16,193— 44.5%
Total prescriptions dispensed	29,768—100.0%	36,392—100.0%
Prescription charge	$20.36	$20.36
Third-party prescriptions	11% (2-15%)	68% (55-99%)

*Based on averages of pharmacies that reported all data

Michael Merson
President & CEO
Helix Health Systems

Health care reform is not a new topic. The national health care debate of the 1960's gave us Medicare and Medicaid. Less than 10 years later, we realized that these two programs were not complete answers and that, in fact, the increased pressures these programs put on the delivery system had created a whole set of additional problems. The next national answer was legislation aimed at cost containment. However, by the early 1980's, continuing public outcry over costs and access underscored the failure of these cost-containment practices. The early experiments in HMOs and managed care began to accelerate and take form as a response and market opportunity.

By the mid 80's the Prospective Payment System (PPS) to contain Medicare spending was introduced but, like it's predecessors, does not produce a stable, basic health care financing and delivery package for society. In fact, it pressures a fragmented health care environment even further into Darwinian practices. It may also inadvertently set a template for the future where all insurers simply draw a line in the sand beyond which they won't pay. The provider community then competes for that "premium dollar" and manages their respective share of it.

Which brings us to the 1990's. Taking a snapshot of health care we see no system. Rather, the picture shows no stable financing mechanism, benefits packages in rapid transition, millions of uninsured, providers in disarray, and opportunity for real change. If we have learned anything from the past, it is that piecemeal reform does not work as anticipated. Therefore, I want to use my time with you today to emphasize the need for a comprehensive approach to health care reform. If we are to find a way to guarantee every American access to a defined, basic set of health care services we must begin by looking closely at each aspect of the health care financing and delivery system and accepting that each piece must change before the system as a whole can move forward. My comments will focus on four main areas: the American society and consumer; health care providers' construct and use of technology; the current inequity in insurance; and finally, the benefits of an all-payor system.

Like every other industry, health care is controlled by basic concepts of supply and demand. As our industry has grown it is primarily in answer to the demand for service placed on us. Therefore, reform should start by examining extraordinary societal demands for health care before the supply side paradigm of delivering this care can be constructed. Increasingly Americans have demanded unlimited access to virtually riskless care. More than thirty billion dollars a year are spent on defensive medicine because of the high threat and cost of malpractice litigation. Providers are asked to care for an infinite variety of societal expectations, dysfunction and havoc which present as clinical problems. Such as the billions of dollars in medical costs due to homicide; billions spent treating smoking related illnesses; 5 to 10 billion dollars at present spent treating Aids cases which could be prevented. Other examples of preventable and behavioral diseases abound. Billions are wasted on "futile care" where the potential benefit from the expenditure is virtually zero. Billions are lost to unnecessary or fabricated workers compensation and other questionable insurance claims. These are the real-life demands that our society places on the health care industry. No reform can be successful unless it attacks the fundamental demand for care.

The second issue is the basic organization of health care providers' and their use of technology. It is no secret that medical specialization and advances in medical technology over

the past three decades have produced awesome results. We routinely perform procedures that were considered science fiction just a few years ago. However, the ability to do more and extend life adds extraordinary cost and focuses medicine on the unusual while diverting money from the basics. The vast imbalance between primary care and specialty providers must be reversed over time. The "biology revolution" may make the "technical revolution" pale by comparison and while the initial products are expensive it portends a true revolution in delivery and the building of an industry without parallel or significant world competition. This should be supported fully as the fundamental economics of other industries show us that efficiency comes when human capital cost is offset by investment in non human capital.

In reorganizing health delivery, we are now able to begin developing initial critical paths and protocols that attempt to standardize how and when medical science and technological advancements can be used. If cost is to be controlled and quality maximized, we must reduce the wide variation in clinical decision making. Current information technology allows rapid access to standards which will improve care giving, clinical outcome and cost effectiveness. New technology and critical path standards can be revised and benchmarked to continuously improve our functioning.

The third issue is insurance reform, particularly reform of the Medicare and Medicaid systems. I believe that Medicare and Medicaid have fueled our society's desire for unlimited consumption and our current free-for-all system. For a minor annual deductible, Medicare beneficiaries have a "comprehensive indemnity plan," irrespective of wealth or health status. They are virtually immune from managed care or the ramifications of their buying decisions. Similarly, Medicaid is for the most part a rich (in benefits) indemnity plan for the poor, the major restriction typically being poor payment to physicians. As a result, access to the system comes from physicians who agree to accept the lowest levels of compensation. This "buy cheap" strategy creates a questionable physician provider structure, and in conjunction with Medicaid recipients' unique demographics, does little to reduce the billions of dollars spent unnecessarily due to this population's tendency to enter the system through expensive hospital emergency rooms or clinics. The irony of this situation is that those of us covered by conventional health insurance, that is non-government financed health care, have a higher probability of having our consumption choices challenged, managed or eliminated than those we support via our taxes. No wonder uninsured and under-insured, working Americans are upset. We need to look carefully at all aspects of the insurance industry. But our first step must be to reform the Medicare and Medicaid programs, bringing them more in line with the realities and restrictions of the private insurance industry. They should be consolidated, placed in a "managed care" context and income tested to the beneficiaries. All insurance vehicles, financed privately or publicly should provide flexibility for those who wish to use discretionary "out of pocket" dollars to purchase extra, different, or more care.

Finally, I want to talk about a different model for "hospital" reform. In following the national discussion of health care reform, a few basic models are coming to the forefront. These include the "pay or play" model that focuses on the employer/employee relationship; the single payor which mirrors the Canadian system; or the tax system model that would use revisions in the tax laws to encourage and/or subsidize the purchase of health benefits by individuals and companies. These are all "financing-insuring" reforms which are abstract and proposed with little analysis of their effect on hospitals and health care providers - still the core of our health care delivery system. All of these proposals and their variations have a high degree of compatibility with something unique to Maryland - the "all-payor system" In 1974, Maryland's hospital costs were the fourth highest in the nation, about 30% above the national median. Today, we are 10% below the national median; an

especially impressive accomplishment when one remembers that Maryland is located in the high-cost northeast corridor. What has made the difference is Maryland's quasi public utility rate-regulation process. Under the law, hospitals may charge only the rates approved by a Health Services Cost Review Commission. These rates include the cost of uncompensated care. Rate review ensures that costs are reasonably related to services provided; that charges are reasonably related to costs; that public access is maximized; and that all payors are treated equally and paid equally. Absent these qualities any of the broader reform proposals will be seriously flawed.

The Maryland system is supported by a wide majority of providers, and unanimously by payors, legislators and the consuming public. Rate regulation has largely met its goal of reducing costs while maintaining individual hospitals' financial viability. The all-payor system eliminates problems that plague the rest of the country such as patient dumping and uncompensated care. Management is restricted from abuse by a set of highly defined rules, sophisticated formulas, and an atmosphere of total public disclosure. Just as importantly, it does not eliminate other free market aspects of health care delivery, such as HMOs, PPOs, and managed care. Finally, the system facilitates a gradual consolidation of the industry which stands in contrast to the nationwide of severe overcapacity and rampant cost shifting for basic survival.

So, in closing, I want to emphasize that, unlike any of the other proposals currently being debated, the Maryland system has been able to demonstrate that it is possible for providers, payors, and consumers to work together. By imposing a number of reasonable restrictions on hospitals and consumers, Maryland has been able to moderate the competitive relationships between providers, payors, and consumers while ensuring financial viability, continued access, and good medical care. As the national debate turns to new solutions, I want to urge this committee to look seriously at its Maryland neighbor as a working model for the hospital component of health care reform.

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STATEMENT

TO THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

THURSDAY, APRIL 23, 1992

DUNDALK COMMUNITY COLLEGE

Re: Health Care Reform

Introduction

The Health Facilities Association of Maryland, representing more than half of the licensed long term care facilities in Maryland, is pleased to present its views on reforming the current health care system. Any reforms must encompass all facets of health care--infancy to geriatrics, private physician visits to institutional care, quality of care, payment for care, etc. While appropriate health care must begin at the prenatal stage, the Association's focus is on reforms in long term health care for the elderly, and specifically institutional long term health care.

It is widely accepted that the nation's elderly population is increasing faster than any other age group. This is causing an increased need for long term health care for the elderly. At the same time, the cost of long term health care has and continues to rise dramatically. Therefore, the focus of any long term health care reform initiatives must address both quality of care and appropriate payment for that care. Satisfying the long term health care needs of the nation will become severely hampered unless the costs associated with that care is addressed. Coordination between the federal and state govern-ments is needed to ensure that payment for services ensure quality of care.

Issues Affecting Long term Care

The enactment of several federal laws and regulations had a dramatic effect on the institutional long term health care industry. Implementation of the 1987 Omnibus Budget Reconciliation Act and subsequent amendments, the Clinical Laboratory Improvement Act, the Americans with Disabilities Act, the Older Americans Act, the Patient Self Determination Act, rules promulgated by the Occupational Safety and Health Administration for the protection of health care workers, rules promulgated by the Food and Drug Administration for the reporting of faulty devices, are just a few of the new requirements with which providers of long term care must comply. While the ultimate goal--to ensure optimum patient care--is agreed upon by all involved, these new rules have caused many changes in the industry. To some extent, these changes will lead the industry into the twenty-first century. Adjusting to these changes, however, continues to be slow.

In addition to the new "legal" requirements, health care has become a highly technical business. Continued rapid advances in medical technology increase the average life span This places several demands on institutional long term care. Individuals are entering facilities at a more advanced age, but also have the potential of living longer once admitted into the facility. At the same time, their health care needs are more acute. While technological advances enable the facility to meet these more acute health care needs, the cost of the technology, both in terms of professional staff, training and equipment, must be recognized and addressed.

OBRA required increased education and clinical training for geriatric nursing assistants. The improvements in technology as well as the increased emphasis on rehabilitation in nursing home will create a need for other specialized staff training. Nurses will need increased understanding of gerontology. Other geriatric "specialists" will be needed in long term care facilities to meet the needs of the residents. This must be considered when adopting health care reform proposals.

Payment

There is no question that long term health care is expensive. Individuals should not be denied necessary health care due to an inability to pay. Private long term care insurance remains a concept which has not become widely accepted. Additionally, such policies will benefit those who are currently in their twenties and thirties, but will not alleviate the current long term health care services funding difficulties. However, this does not mean that the concept should be abandoned. Incentives should be in place to encourage the use of private long term care insurance to eliminate the use of the federal and state governments as the primary "long term care insurers" for institutional long term health care for the elderly.

The Association is aware that consideration is being given to controlling health care expenditures at the federal and/or state level, including establishing rates through an all-payor system in which all payors of health care expenditures would pay the same rate for the same services regardless of the source of funds. If such a system is established, it is essential to ensure that payment levels reflect the different levels of care provided. Any payment should also recognize the special needs of those individuals who, while needing minimal nursing care, require additional supervision due to behavioral disfunction. Fair payments must be balanced with the objective of not exceeding targeted total health care expenditures.

Any legislative initiative must include a definition of reasonable and adequate payment. Otherwise, there will not be a mandated responsibility on the government's part to pay adequately to ensure that the necessary balance between fair payment and targeted health care expenditures is maintained. History has consistently demonstrated that when there is not a mandated requirement to balance potentially conflicting objectives, government has reduced expenditures through the easiest way possible, which has generally been a reduction of provider reimbursement.

Summary

The health care needs of the elderly are ever changing. The days of custodial care in long term care facilities are over. Instead, facilities are caring for the medically complex patient, people with AIDS, and are providing community-based services. It should be noted, however, that all facilities cannot "be all things to all people," nor do they need to be. Not all facilities need to provide care to the medically-complex patient, people with AIDS, or provide the entire array of community-based services. It is for this reason that long term health care should be thought of as a continuum. Individuals needing long term health care services should be appropriately placed within this care continuum. Payments for that care should be made in accordance with the levels needed.

In any long term institutional health care reform, there must be continued emphasis on appropriate payment for each level of care and in each setting. Rates should be established that assure that economically and efficiently operated facilities can cover the costs that are reasonable and adequate to provide care and services in conformity with applicable federal and state laws, regulations, and quality and safety standards. Any reimbursement methodology created should be cost related; administratively effective; recognize the fair value of assets used in the provision of health care; recognize factors which cause cost differentials; attempt to assure that the reimbursement system encourages services to be provided to patients in the most cost effective environment that does not endanger the patients' well-being; include incentives to contain health care costs; and provide mechanisms to influence the supply of necessary health care services and determine that sufficient resources have been provided that assure that quality care can be provided by efficiently and economically operated facilities.

The Health Facilities Association of Maryland appreciates the opportunity to share its views on health care reform with the Committee on Labor and Human Resources. The Association looks forward to providing the Committee additional information on this issue as it relates to institutional long term care in Maryland.

Presented by: Diane W. Curtis

Director, Saint Joseph Hospital Home Care Program

President, Maryland Association for Home Care

I want to thank the Honorable Senator Mikulski for this opportunity to discuss home care as an integral part of the health care system and to share concerns impacting on the delivery of services.

For years the home care industry gained little attention although the first providers of home care services have been in existance for over a century. These precursors of home care were the Visiting Nurse Associations, founded as volunteer organizations to care for the thousands of immigrants entering the eastern port cities of the United States. Awareness of home care has been recent as a result of increased utilization and expenditures.

The major growth in Home Care in the past twenty-five years has been prompted by the enactment of Medicare in 1965. Between 1967 and 1987, the number of Medicare certified agencies has grown from 1,753 agencies to 5,785 agencies. The greatest growth occurred between 1982 and 1987 as a result of OBRA 1984, which initiated the Hospital Prospective Payment System, and a change in the Medicare Conditions of Participation for home health agencies allowing "proprietary agencies" to be Medicare certified. The Health Care Finance Administration reported that between 1982 and 1984, hospital-based home care agencies increased from 507 to 894 (54%), and proprietary agencies increased from 628 to 1,596 (57%). By 1991 HCFA reported there were 2,016 proprietary agencies acccounting for 34.6% of certified agencies and 1,558 hospital-based agencies accounting for 26.7% of Medicare certified agencies.

In addition to the growth in Medicare certified home care agencies, the prospective payment system and the continuing increase in health care expenditures for hospital services resulted in the growth of other home care services. Pediatric home care medical equipment, infusion therapy, chemotherapy and private-pay personal care agencies developed as insurors recognized their cost effectiveness. The National Association for Home Care has identified some 5,500 home care agencies that do not participate in Medicare for a total of over 12,500 home care agencies.

Despite this rapid growth of home care agencies and the increase in expenditures, home care represents a small portion of health care spending. The

National Association for Home Care reported that home care accounted for 2.48% of all health care spending in 1990. Medicare expenditures in 1990 were in excess of $105.4 billion for all care. Estimates indicate that 2.1 million Medicare enrollees received home care services at a cost of $3.5 billion or 3.32% of all Medicare expenditures. However, according to unpublished data recently used in preparing the President's 1993 budget, HCFA estimates home health expenditures have actually increased by 47% in 1990 as a result of clarified policies governing the amount of services a beneficiary could receive. The revised data estimates Medicare home care expenditures at $4.33 billion. This increase is attributed to the increase in visits provided to clients, not the number of clients served. Although it could be argued that this increase was a result of less rigid application of reimbursement guidelines, it is my opinion that patients indeed are being discharged from hospitals with many more health problems. Data collected at my agency substantiates this conclusion. The average number of visits received by each patient has increased from 13.2 in 1989 to 19.6 visits in 1992 to date. Hospital readmissions have increased from 12% in 1989 to over 20% in 1991. Patients requiring laboratory tests to manage their medical conditions have increased as well. Last but not least, the age of patients served has significantly increased with 17% of patients served being over 85 years of age in 1988 to over 21% in 1991. Patients over the age of 75 have increased to over 62%. There is concern that with the increased utilization and subsequent increased expenditures, HCFA will begin looking for ways to curtail costs. This happened in 1987 when the fiscal intermediaries began restrictive interpretations of the guidelines which resulted in beneficiaries not receiving services to which they were entitled. As a result, the National Association for Home Care brought a lawsuit against HCFA by a coalition of U. S. Congressmen led by Representatives Harley Staggers and Claude Pepper. The successful conclusion of this lawsuit resulted in clarification of policies governing the Medicare Home Care benefit. One of the biggest issues was whether patients requiring daily visits met the requirement of intermittent care. The Stagger suit did result in clarification allowing daily visits; however, agencies are still required to put in writing when this level of care will end. For example, if a patient is being treated for decubiti (bedsores), the physician and agency are required to document on orders in the medical record when the bedsore will heal and are left with the problem of what to do

with patients with chronic problems that may never resolve.

One of the greatest dilemmas facing home care agencies is the absence of long-term support services for the chronically ill and elderly who are in need of what is considered "non-skilled" or "custodial services". These services such as personal care, food preparation, shopping, cleaning and other activities of daily living (ADL's) are not covered by any health care insurance, and federal and state funds are desperately lacking. More and more frequently we are seeing patients in their late 80's and 90's who depend on their elderly spouses or children who are in their 60's and 70's with health problems of their own. Community services are so insufficiently funded that they tend to be a frustration rather than a solution. It is at least a weekly occurrence that our agency has to make a referral to Adult Protective Services not because the patients are being physically or emotionally abused, but because the home situation is unsafe for the patient, and family members are unable to accept the alternatives...nursing home or private pay help in the home. Both of these alternatives can deplete any savings by $35,000 to $40,000 a year, if indeed there are savings. Medicaid spend down requirements for nursing home placement reduce the spouses' income to the point that they are left destitute. Is it surprising that families resist these alternatives? I know these issues are not new to this audience, but I feel they bear repeating. Alternatives must be found such as funding for "group living", tax incentives for families caring for the ill and infirm, and for individuals paying for long-term insurance.

Data on the growth of Home Care is most readily available from Medicare as it remains the largest single payor of home care services. However, more data is becoming available as other insurance carriers are recognizing the cost effectiveness of home care and are including coverage for home care in their policies. Aetna Life and Casualty reported a $78,000 per case savings from its Individual Case Management Program using home care for victims of catastrophic accidents. Blue Cross/Blue Shield of Chicago reported that "each of the 65 Blue Cross and Blue Shield plans with case management programs saved an average of $2 million in 1988 as a result of Individual Case Management - a savings of $11 for every dollar spent on the program."

The following is a case study that supports such data. The name of the patient has been changed to protect the privacy of the patient.

Mary Smith was admitted to Saint Joseph Hospital on 3/2/91 with septicemia resulting from cellulitis of the right foot. Mary had a history of juvenile

diabetes for 35 years. As a result of the infection and uncontrolled diabetes, Mary developed respiratory problems necessitating a transfer to the ICU on the third day of hospitalization. She remained on a ventilator for eight days and received multiple intravenous antibiotics. Due to malnutrition and anemia, she was started on total feedings. After being transferred out of ICU, the right foot was debrided which showed an extensive destruction of the foot including tendons. The wound was deep enough to expose bone. She received an allograft three days prior to discharge with plans to give her a homo graft in several weeks. During her hospitalization, Mary's diabetes remained very difficult to control. Mary was discharged on 3/30/91 with orders for home care follow-up. The cost of this hospitalization was over $30,450/$1,088 a day. Blue Cross/Blue Shield of Maryland was contacted and prior approval was obtained for skilled nursing visits three times a week for three weeks. Home care was initiated on 3/31/91 to evaluate for signs and symptoms of infection and to monitor Mary's diabetes and diet, both of which directly affect wound healing. On 4/3/91, Mary returned to the physician's office to have the dressing changed on her right foot. The physician contacted the Home Care department to order twice a day dressing changes and treatment of the wound which was 5 inches long, 1.5 inches wide and 3/4 of an inch deep. Blue Cross/Blue Shield was contacted and services were approved through 4/20/91. Mary's diabetes continued to be difficult to control necessitating frequent changes in her insulin dosage. On 4/14/91 Mary returned to the surgeon's office. The wound was not healing well and had developed a pocket necessitating changes in the treatment and a postponement of the second graft. The wound improved and Mary's diabetes was brought under control. An extension of services was approved by Blue Cross thru 5/11/91. Mary was discharged from Home Care with readmission to the hospital for the second graft scheduled for 5/15/91. The total cost of the home care services was $5,970 or $142 a day. Had Mary remained in the hospital only three more weeks the cost would have been over $12,000. While it cannot conclusively be substantiated, given Mary's history, it is very likely, without the home care services, she would have developed complications such as infection, wound deterioration and other complications secondary to uncontrolled diabetes, such as amputation of her foot

A major concern is that although the cost effectiveness of home care services is an alternative to acute hospital care, there is a shift by some insurance companies to limit the home care benefits to the extent that it becomes ineffective. An example are contracts that allow a maximum of 40 visits a year and disallow such services as physical therapy which the patient would receive if hospitalized.

Other areas of concern are the increasing numbers of uninsured, including the working uninsured and non-elderly uninsured and the effect of case management as it relates to insurance companies. The term "case management" is an amorphous term that has been attached to cost containing activities. As generally interpreted, the term relates to whether or not an individual is eligible for services, at what level of reimbursement, and to the determination of what medical services and amounts will be covered. While case management has the potential to do great good, there is also the potential for great harm. Unfortunately individuals charged with making these decisions frequently lack training and the clinical expertise necessary. In other instances the result is rationing of services to the bare minimum and the utilization of the cheapest provider of services ignoring the quality or lack of quality. Providers are frequently put in a position of "arguing" for services.

A recent example our agency experienced was arranging services for a patient who had an abdominal incision that opened requiring dressing changes twice a day. The wound was approximately 3 inches deep with pockets which required packing with over 5 feet of medicated gauze. The procedure required sterile technique and probing of the wound tract. The patient's husband has poor eye sight and coordination due to a stroke. The insurance case manager required a weekly telephone report for an extension of benefits. After several weeks the case manager reported that their consulting physician felt that the

once a week to evaluate the healing of the wound. To gain approval for continued care the patient's physician had to call the consulting physician and send documentation to substantiate the need for services.

I have had other conversations with case managers suggesting that families and untrained help be "shown how" to make assessments and evaluate the patient's condition. While I agree that some portions of patient care can be delegated with proper instruction safely and effectively, I strongly oppose such

delegation when it is at the discretion of individuals whose motivation is monetary.

I believe most people would agree that insurance companies and the government have the right to accountability, to be assured that funds are used appropriately, and that services purchased are of high quality and necessary. However, I do not think this can be accomplished by increasing control over the providers of service by adding more regulations, increasing paperwork and rationing services. What is needed is cooperation. The government has to admit to the real problems facing this society today. Society and our economy has changed. Our Gross National Product is no longer based on industry. Our population is aging with fewer working people contributing tax dollars. The utilization of health care is rising and will continue to do so. The cost of health care is rising and cannot be stopped by rationing care. Changes must occur, and it is going to be impossible to find solutions that are going to be acceptable to everyone, but changes must be made. Our government has been aware of these problems for years but has found no effective solutions. Our society has also been aware but has objected to all suggestions for change because any solution is going to have a cost attached. Everyone wants a solution, but not at their expense. It is my opinion that if the health care problems facing this nation are going to be solved then everyone must be educated to the problems and possible solutions. Then comes the really hard part ..everyone must cooperate.

I would like to close this presentation with a summary of issues that I hope will be considered by the Senate Subcommittee on Labor and Human Resources when addressing health care reform.

1. Home Care is a cost effective, efficient and effective provider of health care services and should be recognized as such.
2. As more and more health care services are being provided outside of acute care institutions, recognition of home care as an alternative delivery system must be accepted.
3. Over regulation and increased paper work does not assure quality care, but only adds to the cost of services.
4. Meaningful tax incentives must be implemented to enable families to remain out of institutions.
5. Innovative methods of providing long-term care must be found to meet the needs of the aging population.

Figure 1. Number of Medicare-Certified Home Health Care Agencies, 1967–1991

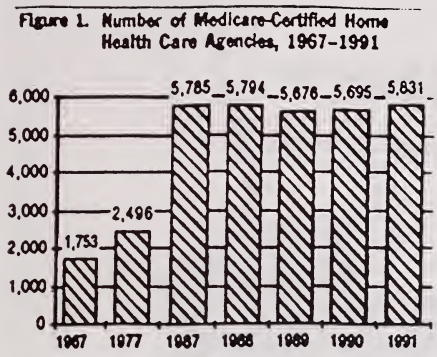


Figure 2. Number of Medicare-Certified Home Health Care Agencies by Auspice, 1967, 1987 & 1991.

	1967		1987		1991	
Auspice	*No.*	*%*	*No.*	*%*	*No.*	*%*
VNA	642	36.7	551	9.5	525	9.0
Official	939	53.6	1,073	18.5	932	16.0
Proprietary	0	0	1,846	31.9	2,016	34.6
PNP	0	0	766	13.2	683	11.7
Hospital	133	7.6	1,439	24.9	1,556	26.7
Other	39	2.2	110	1.9	117	2.0
Total	1,753	100.0	5,785	100.0	5,831	100.0

to Home Care, Selected Conditions

Condition	*Cost of Hospital care*	*Cost of Home care*	*Dollar Savings*
Infant born w/ breathing & feeding problems	$60,970	$20,209	$40,761
Neurological disorder w/ respiratory problems	17,783	196*	17,587
Ventilator-dependent patient care	24,569	1,786	20,893
Nutrition infusions	23,670	9,000	14,670
Antibiotic infusions	7,290	2,070	5,220
Patient requiring respiratory support	24,715	9,267	15,448
Quadriplegic patient w/ spinal cord injury	23,862	13,931	9,931
Cerebral palsy patient	8,425	4,667**	3,558

*After initial cost of equipment **In extended care unit of hospital

Figure 6. Products and Related Home Care Services, 1986 & 1991

Market segment	*Revenues (in millions) 1986*	*1991*	*Average Annual Growth*
Parenteral & enteral nutrition programs	$415.2	$924.0	17.3%
Home antibiotic & chemotherapy	48.0	181.0	31.5%
Respiratory therapy, equipment & gas	350.1	556.0	9.7%
Renal dialysis supplies & services	348.9	618.0	12.0%
Incontinence products	311.0	425.0	6.4%
Durable medical equip.	285.4	435.0	8.8%
Ostomy products	252.1	336.0	5.9%
Pressure care products	56.3	95.0	10.3%
Apnea monitors	11.7	21.0	12.4%
Transcutaneous electronic nerve stim.	44.6	80.0	12.4%
Total	$2,123.2	$3,669.0	6.9%

Figure 3. Medicare Home Care Expenditures and Utilization for Selected Years *(in millions)*

Year	*Total Reimbursement*	*Patients Served*	*Avg. Charge per Visit*
1967	$46	N/A	N/A
1977	406	N/A	$29.00
1987	2,335	1.544	61.00
1988	2,313	1.460	64.00
1989	2,563	1.661	64.00
1990	3,473	2.065	68.00
1991	3,806	N/A	70.00

Figure 4. Medicaid Home Care Expenditures and Recipients for Selected Years

Year	*Payments (millions)*	*Recipients (thousands)*	*Payment per Recipient*
1977	$ 180	371	$ 485.00
1987	1,690	609	2,777.00
1988	2,015	569	3,542.00
1989	2,572	609	4,225.00
1990	2,600	N/A	N/A

Figure 5. Home Care Expenditures Compared to All Health Care Spending, 1990

	All care (billions)	*Home care (billions)*	*Percent Home care*
All payors	$553.0	$16.2	2.46%
Medicare	105.4	3.5	3.32%
Medicaid	54.6	2.6	4.77%

Figure 9. Number of Clients, by Type of Provider, in Home Care, 1987

Type of Provider	*Clients*
Homemaker-home health aides	2,643,000
Nurses	2,143,000
Doctors	969,000
Therapists	633,000
Other (medical)	1,512,000
Total	5,878,000*

*The numbers do not add up because some individuals receive services from more than one type of provider.

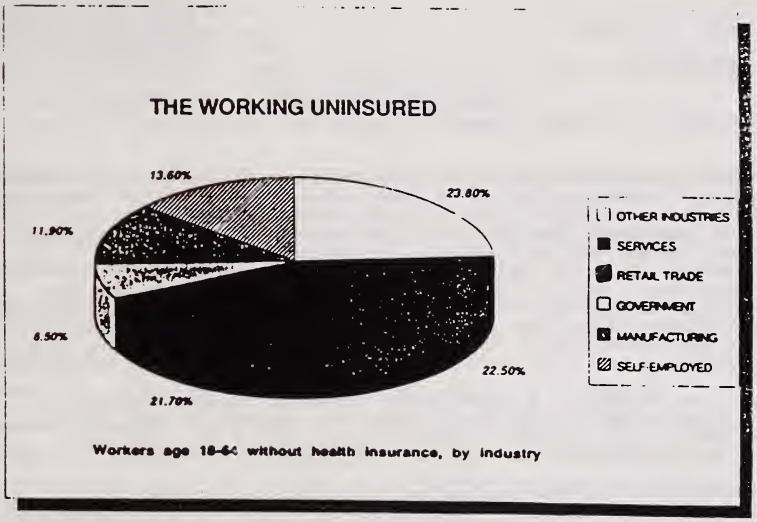
Figure 10 shows the number of providers, by type, for Medicare-certified home care agencies only in 1986, along with per-agency averages for each provider type.

Figure 10. Number of Providers, by Type, Working in Medicare-Certified Home Care Agencies, 1986

Providers	*Salaried*	*Contract**	*Total*
RN	39,552	1,680	41,232
LPN	3,827	163	3,990
Physical therapists	6,234	7,902	14,136
Occupational therapists	1,997	1,807	3,804
Speech therapists	3,113	6,215	9,328
Homemaker-home health aides	26,324	7,302	33,626
Other	23,991	521	24,512
Total	105,038	25,590	130,628

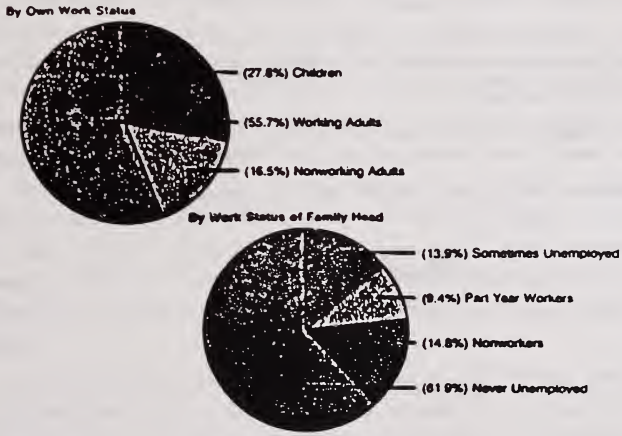
Compared with Medicare-Certified Agencies, by State, 1991

State	All Agencies	Certified Agencies
Alaska	33	10
Alabama	268	120
Arizona	149	82
Arkansas	214	169
California	963	367
Colorado	185	109
Connecticut	202	108
District of Columbia	29	15
Delaware	39	21
Florida	552	248
Georgia	271	71
Hawaii	55	23
Idaho	46	28
Illinois	567	251
Indiana	302	135
Iowa	246	152
Kansas	292	130
Kentucky	174	102
Louisiana	303	197
Maine	68	22
Massachusetts	321	151
Maryland	207	73
Michigan	469	162
Minnesota	316	196
Mississippi	147	80
Missouri	280	187
Montana	75	45
Nebraska	105	47
Nevada	54	23
New Hampshire	97	39
New Jersey	284	67
New Mexico	93	52
New York	1,015	207
North Carolina	342	131
North Dakota	94	30
Ohio	437	244
Oklahoma	178	87
Oregon	109	60
Pennsylvania	485	252
Puerto Rico	65	44
Rhode Island	63	14
South Carolina	178	48
South Dakota	115	18
Tennessee	399	258
Texas	991	481
Utah	67	37
Vermont	34	16
Virginia	327	156
Washington	194	54
West Virginia	116	69
Wisconsin	325	182
Wyoming	91	33
Totals	12,536	5,851



Source Modern Healthcare, May 27, 1991

The Nonelderly Uninsured, 1988



Source: A Tradition of Service: Environmental Assessment 91/92. American Hospital Association. 1991.

412 Carolina Road
Towson, MD 21204
April 23, 1992

Testimony for Senator Mikulski's Health Care Hearing April 23, 1992

Senior citizens consider their top priority health care reform. Health care can be a devastating burden in their golden years. Just the knowledge that their entire retirement future can be changed overnight can drain the joy out of retirement. Please consider the will of the people including the seniors who are the major users of health care.

In my activity with Baltimore County Association of Senior Citizen Organizations (BCASCO) and United Seniors of Maryland (USM) I have learned that most of the seniors feel a major change is needed in health care reform at the national level. It is important to include long term care in the legislation.

I urge you to support a single payor system as the most rational approach to solve the many complex problems of health care. Only on a national level can we control the costs and provide a fair and just coverage for all the people in the United States.

The Russo bill H.R.1300 and now the Wellstone bill S.2320, both single payor bills, are the best solutions. To try to modify the existing system will not correct the inefficiencies and high cost present in health care in the United States.

There are large corporations in the health care field that will be affected but I ask you to consider the long time we have tried to work within our system. Large profits have accrued to special interest groups and costs have continued to escalate at a much faster rate than inflation.

If the plan is structured correctly, I feel much of the insurance burden can be lifted from small and large businesses. This will allow them to be more competitive in world markets with other industrial nations that already have national health care systems.

It is our moral obligation as the richest industrial nation to provide health care for everyone in our country. Too long we have not heard the suffering people in our own country as each individual strives to improve his or her own position in society.

As a former social worker you are one of the few that understands the needs of the poor and nearly poor whose voices are often not heard.

I hope you can support the major change that is needed to give us health care for all.

Charles Culbertson

Charles Culbertson

mota

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Maryland Occupational Therapy Association

The Maryland Occupational Therapy Association's Position on Health Care Reform

The Maryland Occupational Therapy Association (MOTA) is a non-profit organization which serves to improve and advance the practice of occupational therapy, foster research and the study of occupational therapy, and advocate for the availability of occupational therapy services. Occupational therapy is a health related profession that is over 75 years old; it promotes the ability of individuals to perform the tasks which are required to function as independently as possible in their life roles (e.g., worker, parent, student). As health care providers we are deeply concerned about the many citizens in the state of Maryland as well as citizens of the United States who currently lack access to preventative and rehabilitative services.

Currently in the United States disparity exists both in terms of health care status and access to health care between differing socioeconomic segments of our population. For example, the 1990 Health and Human Services report *Healthy People 2000* stated that death rates were twice as high for people having lower incomes than for those whose incomes are higher. Individuals from low socioeconomic groups have an increased risk for heart disease, cancer, infant mortality, and chronic disease. These individuals also have difficulty accessing: (a) information on risk factors and health behavior change, (b) preventative screenings to diagnose the conditions early and provide early intervention, and (c) rehabilitative services which can prevent further complications and allow these individuals to remain functional in their communities.

The goals stated in the report *Healthy People 2000* are visionary, and are necessary to ensure that all citizens have the opportunity to live productive and healthy lives. The achievement of these goals relies on coordinated community efforts; collaboration between allied health professions, communities, and government; and successful reform of the current health care system.

The MOTA supports the goals outlined in *Healthy People 2000* and the need for health care reform. The MOTA wishes to present its perspective regarding national health care reform. We are in agreement with the National Rehabilitative Caucus' (NRC) Position Statement on Health Care Reform. The NRC recommends the following four elements be included in any initiative to reform the national Health Care System:

(1) Universal Access/Nondiscrimination

"All Americans, regardless of age, income, disability or employment, must have access to a basic package of appropriate, affordable, quality health care" (NRC). The MOTA is particularly concerned about those individuals with

disabilities who are unable to receive health care coverage due to current practices which exclude individuals based on preexisting conditions or inappropriate waiting periods. The report *Healthy People 2000* estimated that the number of individuals with "chronic, significant disabilities vary from 34 million to 43 million." In Maryland it is estimated that over 253,000 citizens between the ages of 18 and 64 have conditions which interfere with the completion of their daily life activities and more than 125,000 are severely disabled, preventing them from participating in many life roles (e.g., worker, student). Without access to rehabilitative services these individuals are at greater risk for costly secondary health problems and greater dependence on support programs.

Chronic mental health conditions are typically not focused on during discussion of people with disabilities. Chronic and acute mental health disorders can disrupt an individual's ability to complete the tasks which are necessary in order to function independently in the community. It has been estimated that 5% of Americans are affected by depression at any time, and that approximately 23 million non-institutionalized American adults have cognitive, emotional, or behavioral conditions other than alcohol and drug related conditions. Early intervention, rehabilitation, and follow-up are required in order to prevent either the development of secondary health problems in the individual and/or their support system, or an acceleration in symptomatology.

(2) Comprehensiveness

"Health care reform should assure the availability of a full range of services necessary to provide a continuum of quality care, and should provide adequate access to these services in the most appropriate settings. A core health benefits package must include coverage of medical rehabilitative services in hospital and home and community-based settings" (NRC).

The MOTA would like to emphasize that a comprehensive plan must include rehabilitative services for individuals with physical, cognitive, and psychosocial disabilities and provide coverage for services across settings (inpatient, outpatient, home health etc.) which are cost-effective means of maximizing function. A comprehensive plan would include but not be limited to coverage for the screening, rehabilitation, preparation, and support for independent living in the areas of work, self-care, and leisure. It is imperative that assistive technology (which ranges from orthotics, to bath tub benches, wheelchairs, computers, and environmental control systems) and related services (which include the assessment for, customization of, and repair of assistive technology) be included in a national health care reform plan to assist the individual in maximizing their potential for independent living.

(3) Quality/Appropriateness of Care

"The promotion of appropriate, quality care is essential to a health care system that values outcomes while containing costs" (NRC). The MOTA fully supports and encourages research-based practice and continuous quality improvement monitoring. The NRC reports that the insurance industry has "a savings of $11 for every $1 invested in rehabilitative services." Other studies have reported similar findings.

(4) Efficiency and Equity

"An efficient and equitable health care system should appropriately distribute resources, as well as responsibility, and must include effective and fair cost-containment mechanisms." The MOTA agrees with the NRC that services must be made available on a continuum starting with preventative services and including acute care, rehabilitative services and continued care. Preventable conditions were responsible for costs equivalent to 18% of the Gross National Product. The report also found that many groups do not have equal access to services which can prevent these conditions. These groups include people with low incomes, people in minority groups, and people with disabilities.

The Senate Democratic leadership has introduced significant legislation to begin the process of health care reform. We believe that S. 1227 contains many positive features which are consistent with the principles necessary for effective reform. We believe, however, that refinements to the proposal are essential if it is to meet the stated goal of providing access to quality, cost-effective health care for all Americans.

Specifically, the revised version of S. 1227 that has been reported by the Labor and Human Resources Committee provides inadequate coverage of medical rehabilitation services under both the employment-based benefits package and AmeriCare, the public health insurance plan. In fact, the benefits would represent a significant regression from current coverage of medical rehabilitation services under public and private insurance plans.

The employment-based benefits package requires coverage of hospital and physician services, diagnostic tests, limited mental health benefits, prenatal and well-baby care and some preventative services. Medical rehabilitation services are omitted from the specified benefits included under the definition of hospital services as traditionally defined by the insurance industry and the Social Security Act. However, community-based rehabilitation services such as those furnished by comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and clinics and independent practitioners would not be covered.

AmeriCare, the public health insurance plan, would replace the existing Medicaid program (except for long-term care services) and provide the same scope of benefits as for employment-based coverage. In addition to the basic benefits, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children under the age of 21 would be covered. EPSDT services incorporate coverage of medical rehabilitation services. However, almost all existing state Medicaid plans currently provide coverage of medical rehabilitation services in a variety of community-based delivery settings for the broader eligible population.

The Maryland Occupational Therapy Association is advocating for the reform of our national health care system. Representatives of the MOTA would welcome the opportunity to discuss prevention and rehabilitation activities which would support the United States' efforts in the area of health care reform, thereby allowing us to meet the goal of enabling all persons to maximize their potential for successful living.

Suzanne Santora, C.D.M.
Dietary Managers Association
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I am addressing the health reform issue that deals with furnishing congregate and home delivered nutritional services.

A certified dietary manager should be the primary person responsible for preparation and delivering these meals. They have the education, training and experience to see that citizens are receiving the correct nutritional diet.

Those civic organizations and institutions, such as jails who provide meals on wheels, need to have a qualified supervisor in the facility to ensure that nutritional values and quality meals are provided.

Many times the provider of meals on wheels inappropriately serve meals for the elderly and disabled not knowing their dietary requirements. The importance of the correct diet being available is the foundation in preventing and controlling illness and disease. Malnutrition is a problem with our senior citizens who have food that is inappropriate in meeting their dietary needs.

Brownies make a great dessert but not for someone who is a diabetic. Cottage cheese is a soft food but presents a problem to those with swallowing disorders (dysphagia).

Organizations and institutions who provide these services should insure that all their good efforts produce a nutritional end product that is beneficial to the recipients and not a hindrance to their health.

Respectfully submitted,

Suzanne Santora
Food Service Director

Statement of the Maryland Office on Aging Regarding the Need for Health Care Reform

Senator Mikulski and Committee Members:

My name is Michael Lachance, Legislative Liaison for the Maryland Office on Aging. The Office thanks the Committee for the opportunity to offer comments on the pressing need for health care reform in Maryland and throughout our nation. In my comments today, I would like to focus on the one specific area of health care policy which impacts most dramatically on older persons—the lack of effective long-term care financing for disabled people of all ages.

In Maryland an estimated 113,000 persons over the age of sixty are moderately to severely disabled (15% of the 60+ population). Of these, we estimate that there are over 46,000 low-income, disabled seniors who need publicly funded home care and are not receiving it. This represents and increase of about 11% over our estimate a year ago.

Maryland has been a leader in the development of health care for the indigent and community-based care for the disabled. Prior to the passage of federal legislation which established the Medicaid program, Maryland had in place a state-funded health care program for the poor. In the 1970's, Maryland established a community home care program for the disabled. The "Senior Assisted Housing Program", originally known as "Sheltered Housing", became a national model for providing assisted living to frail elderly in independent living arrangements.

During the period of the 1980's, when the "Channeling" demonstration projects were being tested across the country, Maryland established its own pilot program to provide comprehensive community-based care, then called "Gateway II". Our "Senior Care" system, as it is now known, provides a comprehensive assessment of needs, case management, and for low-income seniors, the use of "gap-filling" funds to purchase needed goods and services unavailable through other government administered programs.

Maryland's Senior Assisted Housing Program and the Senior Care system have proven themselves cost-effective and humane alternatives to nursing home placement, where Medicaid ultimately ends up paying the bill for 60% of nursing home residents. While it was never intended to be the primary payer of long-term care, Medicaid is in fact the only government long-term care financing vehicle in place. The proven experiences of Maryland and other states in administering cost-effective, community-based alternatives to Medicaid should be supported by the federal government as one component in any comprehensive health care reform action.

Senior citizens sent that message to Congress three years ago when the revolt against the now repealed Medicare Catastrophic Care legislation took place. The real catastrophe against which seniors needed insurance is for the astronomical costs associated with long-term care.

While the Office on Aging does not support any specific legislative proposal at this time, access to long-term care is the single most important priority of the elderly. As a first step in implementing health care reform in this nation, a comprehensive long-term care program, financed along the lines of Medicare should be established for disabled people of all ages. This program should provide for both community-based and institutional care.

The successful experiences of states like Maryland in establishing cost-effective approaches to long-term care through community-based services should serve as models for any national health care reform.

Thank you.

arc/washington county

Washington County Association for Retarded Citizens

827 Marion Street, Hagerstown, Maryland 21740
(301) 733-3550

April 23, 1992

Senator Barbara A. Mikulski
Suite 320
Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Mikulski:

Thank you for your invitation to attend the public hearing on health insurance and health care reform. Although, I was not able to attend the hearing, enclosed are my thoughts on the subject for inclusion in your record.

The cost should be the same for each person. If an employee works for an organization employing five persons or an organization employing five hundred persons; the premium charged for each individual should be the same dollar amount.

The benefits should be the same for everyone. If an individual lives in Hagerstown, Maryland or Oakland, California; the benefit should be the same.

All employees must contribute a percentage of the premium amount. Whether that percentage be ten percent, twenty percent or thirty percent; the employer should not be required to provide the benefit without cost to the employee.

The last point is that rates for services should be set and must be accepted by all physicians with out exception.

Thank you for the opportunity to express my opinions on the matter.

Sincerely,
Washington County Association
For Retarded Citizens

Bob DeHaven

Robert E. DeHaven
Executive Director

TESTIMONY REGARDING HEALTH CARE HEARING
Labor and Human Resources Committee
United States Senate

The Epilepsy Association of Maryland has been extremely concerned about the health care financing needs of people who have chronic health conditions such as epilepsy, diabetes, cerebral palsy, or multiple sclerosis. We believe that all citizens have a right to adequate and affordable health care. Our current patchwork of private, employer supported health insurance and public "safety nets" does not meet the needs of more than 34 million Americans. Our criteria for a universal, affordable and adequate health care financing system include the following:

Health care plans must all offer comprehensive benefits without an excessive financial burden.
We can demonstrate, based on extensive experience, that, if the coverage isn't comprehensive, it simply isn't adequate. Basic or minimum benefit health care plans may be acceptable for a few people who aren't likely to need medical care. Even people who see themselves as healthy, however, would do well to utilize preventive services, and anyone can have an accident, or need surgery, or give birth to a child with ongoing health care needs.

Adequate health care coverage must be comprehensive. This is particularly important to people who have a diagnosed, long term health problem with predictable and costly medical needs. They must see their managing physician routinely - and that physician may need to be a specialist. Periodic diagnostic or status assessments are often needed, as well as daily medication.

It is important that we not relegate the issue of predictable, specialized medical expenses to a problem for an unfortunate few. For epilepsy alone, for example, it is estimated that at least one in every hundred people receive medical care regularly. That adds up to about 40,000 people in Maryland.

Health care cost coverage must be available to all people without underwriting or exclusions for preexisting conditions.
No private insurance company will sell an individual policy to cover the health care needs of a person who has had even one convulsive seizure within the past five years. Epilepsy is one of several common "pre-existing conditions" which health insurance companies systematically exclude from coverage. Our system is built on a foundation of private, for-profit health insurance, and one of the key mechanisms to ensure profitability is underwriting. All too often, people who have a diagnosis which indicates a need for medical care cannot get individual health insurance, or they find that they cannot afford the premiums charged to counter their predictable need for care. Even those who are fortunate enough to be able to access group coverage may find that their preexisting condition is excluded, or that the insurance carrier puts pressure on the employer to withdraw coverage from someone who has predictable high health care costs.

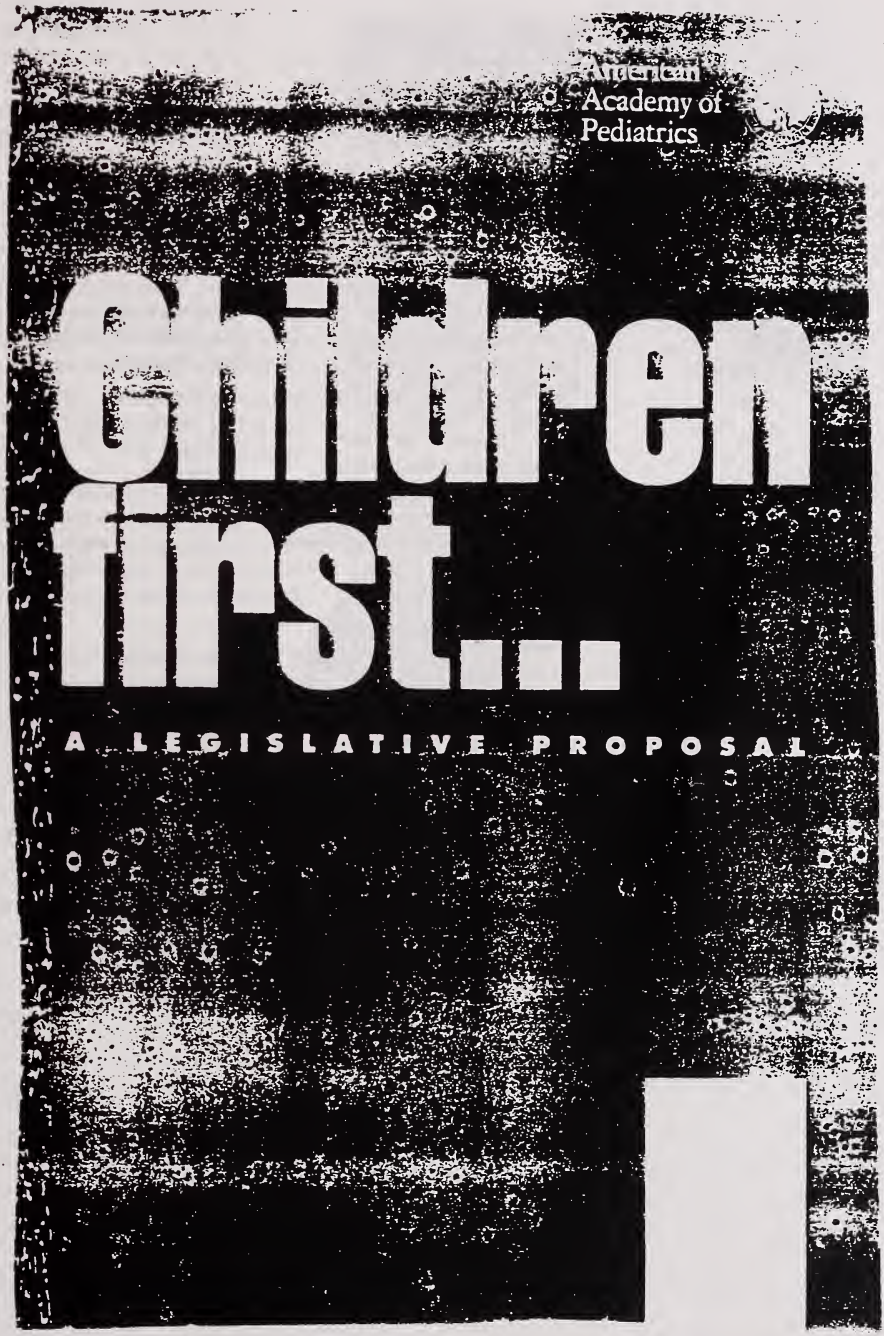
The cost of financing an equitable, universal health care system must be shared by the entire population, and not directed only toward those with identified health care needs.
At the Epilepsy Association, we are often asked to assist people with epilepsy to obtain coverage for their health care costs. We urge individuals to find the cheapest bulk mail purchase service for obtaining their medication, and we try to help them to find employment with a firm which has a group policy available to all employees without medical "underwriting" and the option to exclude them because of their epilepsy.

We have assisted many, far too many people to apply for Medical Assistance and Pharmacy Assistance. The cost of treatment is so high that many people without access to private health insurance become impoverished enough to be eligible for public programs. We talk with people who see their pay checks going to cover the cost of their treatment. We talk with others who don't work, so that they will at least have access to Medical Assistance. Many marginally employed people with epilepsy must weekly juggle their rent and their fuel payments and their food budgets, with the pressure to pay their medical bills. Sometimes that gets resolved when they get expensive, last resort treatment in a hospital emergency room. Emergency rooms in Maryland are not allowed to turn people with no health insurance away, and so health care gets postponed until it becomes an emergency, and then the costs for "uncompensated care" are shifted back into the payers in the system.

The time has come for us to develop a health care cost coverage system which is universal, affordable, and comprehensive:
. No one should be excluded from access to adequate health care - no one should be penalized - because of the extensiveness of their health care needs.
. No one should be told that they have health care cost coverage, only to learn when they try to use it, that it doesn't cover treatment that they need.
. Health care should not be dependent upon employment status, or upon the variations in coverage plans to which a family has access.

The financing of a universal system must be shared by all citizens, without a disproportionate burden on any individual or group. The health care available must be comprehensive, covering more than basic or catastrophic costs. It should cover the special needs of persons with chronic illnesses, and it should cover primary and preventive care.

We must do more than just tinker with, and add costly layers to our current fragmented inequitable system. We must assure that all Marylanders can access health care which is affordable and comprehensive. We urge Senator Mikulski to continue the leadership she has begun to develop and gain acceptance for a Universal Health Care system. Those affected by the health care crisis need assistance now!


American
Academy of
Pediatrics
Children
first...
A LEGISLATIVE PROPOSAL

Children first...

IN THE MOVEMENT TOWARD UNIVERSAL ACCESS TO HEALTH CARE

As America approaches the 21st century, it is painfully clear that, despite our best efforts, there remains more promise than progress in maternal and child health programs. Although health care costs exceed 11 percent of our gross national product, the health status of American children is declining. This comes at a time when the problems confronting children have become increasingly complex.

Pediatricians know these problems all too well. Over the years, members of the American Academy of Pediatrics (AAP) have expressed their concerns and advocated necessary policy changes. These problems have been the subject of countless studies, commissions and congressional hearings. Rhetoric by national policymakers is laudable, but the statistics argue for immediate action.

- The percentage of fully immunized two-year-olds is decreasing. One in four American children is not immunized against diseases including measles, whooping cough, mumps and polio. Outbreaks of these preventable diseases are increasing.
- The United States surpasses almost all other developed nations in adolescent pregnancy, school failure, adolescent suicide and sexually transmitted diseases.
- One in six children in the United States lacks health insurance coverage.
- One of every four pregnant women is not insured for maternity care, and an equal percentage do not receive any prenatal care during the first trimester.
- The United States ranks 21st among industrialized nations in infant mortality. For black children, the U.S. ranks far lower.

America's health care system is failing to meet the needs of children and pregnant women. Moreover, the gap is widening between Americans who can avail themselves of the best medical services in the world and those who cannot obtain even basic acute illness and preventive care.

Lack of health insurance is the most significant barrier to access to health care in our country. Of the more than 30 million Americans without health insurance, a disproportionate number are children and pregnant women. Contrary to popular belief, the typical uninsured child is white, has a working parent and lives in a two-parent family with an income above the federal poverty level. Even more children are under-insured; their common and relatively inexpensive needs — preventive care and outpatient care for acute illness — are covered poorly, if at all. In addition, many children are declared uninsurable because of chronic illnesses, handicapping disorders or other preexisting conditions.

Insurance problems affect children even before they are born. Today, 14 million women of childbearing age have no maternity care insurance. This often results in delay or absence of prenatal care, and it is clearly linked to high rates of low birthweight and infant mortality.

The major reason for the growing number of uninsured is the decline in dependent coverage by employers. As recently as 10 years ago, 40 percent of employers paid for dependent coverage in full; today only 33 percent do.

This situation is likely to disintegrate even further. As health care costs continue to rise, the proportion of dependents with job-based health insurance coverage will continue to shrink. Small employers face increasingly prohibitive costs in the private insurance market, and large employers are reducing benefits and dropping coverage in an effort to curb costs. Because of limitations on age, family income and availability of services, public programs fail to cover millions of children living in poverty.

When children and pregnant women do not receive the health care they need, who pays? We all pay.

AGE DISTRIBUTION OF THE UNINSURED POPULATION UNDER THE AGE OF 65, 1984

1. Children 0-17 years of age
   33% — 11.6 million
2. 18-24 years of age
   24% — 8.3 million
3. 25-34 years of age
   18% — 6.2 million
4. 35-44 years of age
   10% — 3.4 million
5. 45-54 years of age
   8% — 2.7 million
6. 55-64 years of age
   8% — 2.9 million

Source: Census, unpublished data from the March 1985 Current Population Survey.

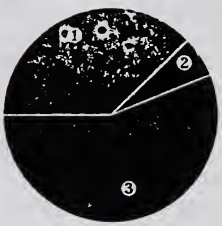
CLIMATE FOR CHANGE

An increasing awareness of the problems of the uninsured and the soaring cost of health care has created a strong impetus for broad reforms in the American health care system.

Employers, insurers, health care providers and labor unions derailed the movement toward compulsory health insurance in this country after World War I. These major players have taken different positions over the years, but today they are joining forces under the banner of reform. Spurred on by increasing need and a frustrated public, these disparate groups are working to find solutions. The status quo is no longer an option; change is coming in this decade.

Pediatricians, who are taking the lead to ensure that children and pregnant women are treated fairly, know that providing coverage to children first is logical, humane and economical. Paying for the preventive and acute illness care children and adolescents need now will save money in the long run. To this end, the Academy has launched an ambitious, long-term initiative to ensure access to affordable comprehensive health care for all children through age 21 and all pregnant women. The Academy is concentrating its efforts in three areas: federal legislation, community-based projects providing health care for children, and public education to increase awareness of access problems and to promote utilization of appropriate preventive services. This document provides details of the AAP legislative proposal developed with the technical assistance of Lewin/ICF, a Washington-based health policy research firm.

TYPE OF FAMILY WHICH UNINSURED CHILDREN LIVE, 1984



1. Female Head
   38%—4,461,000
2. Male Head
   6%—659,000
3. Married Couple
   56%—6,498,000

Source: Census, unpublished data from the March 1984 Current Population Survey

THE ACADEMY PLAN

KEY CONCEPTS

- All children up through age 21 and all pregnant women will be *guaranteed financial access* to necessary, appropriate and effective health care services, regardless of family income, employment status, ethnic origin, geographical location or health status.
- A *one-class system* of medical care will be established by replacing, with private insurance, the portion of the Medicaid program currently serving children and pregnant women, and by requiring uniform benefits.
- All segments of society — individuals, the private sector and government — will have a *shared* responsibility for *funding* the system.
- The *patient will choose* an insurance plan and his or her physicians; similarly, *physicians will choose* acceptable plans and caseloads.
- Administrative procedures will make this system *user friendly*.
- *Compensation* for services will be set by the *marketplace*, not the federal government.
- *Costs will be contained* through increased use of preventive services, use of case managers and cost sharing.

The American Academy of Pediatrics plan is designed to be the cornerstone of a national health plan for all Americans, building on the current free enterprise system of health insurance and the shared financial responsibilities of the public and private sectors. It will provide prenatal, preventive, acute, chronic and rehabilitative services to all children and pregnant women, regardless of level or source of income.

All children and pregnant women will have access to private health insurance through either an employer or a state administered insurance fund (SAIF). Employers will be given the option of providing insurance for dependents or paying a tax to the SAIF. Whether children and pregnant women receive private insurance through an employer or the SAIF, they will receive the same comprehensive package of benefits. The AAP model will rebuild the foundation of the American health care system, starting with children and pregnant women.

GUARANTEED FINANCIAL ACCESS

Under the Academy proposal, all children and pregnant women will be covered by private health insurance, removing any financial barrier to the receipt of necessary care. Each child or pregnant woman will receive an insurance card entitling him or her to private insurance from an employer or from a state administered insurance fund.

ONE-CLASS SYSTEM

While the Academy is supportive of Medicaid expansions as a short-term solution to access problems of low-income mothers and children, clearly it is not the model on which to base a national plan. Under Medicaid, access to appropriate care is severely compromised by inequities in eligibility, restricted benefits, and limited availability of services due to declining provider participation. Administrative barriers and the program's welfare stigma are additional problems.

The Academy's proposal is designed to revamp the current system that promotes inequities in access to care. Central to the AAP proposal is the transfer of federal and state Medicaid dollars currently expended for children and pregnant women to the new state administered insurance fund.

▶ STATE ADMINISTERED INSURANCE FUND

The AAP plan will require a state office totally separate from the existing Medicaid and welfare systems to contract with multiple insurers for private insurance for all children and pregnant women who do not receive employer-based insurance. All children and pregnant women not covered through the employer-based system will be covered by the SAIF.

▶ UNIFORM BENEFITS

The Academy's proposal includes federally specified benefits. Insurers, whether contracting with the state or with an employer, will be required to provide a standard benefit package. (See table 1.) Benefits for children will include preventive health care in accordance with the Academy's recommended schedule, care for acute and chronic illness, rehabilitative services and care requiring coordination of services. In addition to the American College of Obstetricians and Gynecologists' prescribed schedule of prenatal visits, pregnant women will receive care for any acute or chronic illness that might affect their health or the health of their fetus.

TABLE 1—BASIC BENEFIT PACKAGE

❶ Preventive Care Benefit Basket: Specific benefits for which no cost-sharing applies. All preventive services should be covered according to the AAP periodicity schedule:

- Child preventive care, including:
  - —Routine office visits
  - —Routine immunizations
  - —Routine laboratory tests
  - —Preventive dental care
- Prenatal care, including:
  - —Care of all complications
  - —Family planning
- Care of newborn infants, including:
  - —Attendance at high-risk deliveries
  - —Normal newborn care (inpatient)
- Child abuse assessment

❷ Primary/Major Medical Benefit Basket: Specific benefits for which some cost-share applies:

- Hospital services
  - —All inpatient care for acute and chronic conditions
  - —Emergency room care
  - —Transport to hospital or health facility
  - —Treatment for injury to normal gums and teeth
  - —Acute home health care on a short-term basis
  - —Surgery and anesthesia services
  - —Therapeutic radiology services
  - —Nursing care
- Physician services
  - —Inpatient and outpatient physician care for acute and chronic conditions
  - —Subspecialty consultations and treatment
- Diagnostic services
  - —Diagnostic radiology services
  - —Laboratory tests
  - —Diagnosis of developmental and learning disorders
- Acute dental care
- Medical and surgical supplies
- Corrective eyeglasses or lenses
- Hearing aids
- Medical equipment
- Prescription drugs, including nutritional supplements

❸ Extended/Major Medical Benefit Basket: Specific benefits for which cost sharing applies. Criteria will be established to trigger the need for care coordination. Primary care physician will be involved in development of plan of care.

Services include:

- Care coordination for chronically ill and other "at-risk children"
- Orthodontia not covered above (other than cosmetic)
- Treatment of developmental and learning disabilities
- Mental health services
- Substance abuse services
- Speech therapy
- Occupational therapy
- Physical therapy
- Hospice care
- Respite care
- Recuperative stays in long-term care facilities
- Nutritional assessment and counseling

TABLE 2—COST-SHARING STRUCTURE STATE FUND

Family Income Level (Expressed as a percentage of the Federal Poverty Level)	Annual Premium Share	Annual Deductible	Coinsurance		
			Category 1: Preventive Benefits	Category 2: Primary/Major Medical Benefits	Category 3: Extended/Major Medical Benefits
200% or More	Variable Up to 25% of Cost of Plan Not to Exceed $458*	$200	No Deductible or Coinsurance Regardless of Income Level	20%	30%
150% - 200%		$150		15%	22.5%
133% - 150%		$50		10%	15%
Less than 133%	None	None	None	None	None

Note: A catastrophic cap of 10% of family income to a maximum of $3,000 per family or $1,000 per beneficiary limits out-of-pocket expenditures.

No insurer will be allowed to exclude coverage of any preexisting condition. States will enact rules for insurance companies based on federal regulations. The Secretary of Health and Human Services will guide development of these federal regulations.

SHARED FUNDING

Individuals, the private sector, and state and federal governments will share in funding the system. The federal government will apportion funds from these sources to the states on the basis of the projected number and age of the beneficiaries enrolled in the state plan. Employers will be required to provide an insurance package with specified benefits for dependents and pregnant employees, or pay a 3.17 percent tax* on the wages of all employees, up to the Social Security wage base. This requirement will apply equally to employers who currently offer limited coverage for dependents, who offer no dependent coverage or who offer no employee health insurance.

The above requirement may present a hardship to small employers who have been unable to purchase group insurance either because of cost or unavailability. Health insurance reforms will be required to guarantee the availability of insurance to all small groups and to set equitable premium rates for all purchasers within the same geographic area. Tax deductions and tax credits are also viable options.

The share of a dependent's premium paid by the employee must be no more than the share that the employee pays for his or her own premium, and in any case, may not exceed 25 percent of the total premium. Payroll taxes and premium rates will be adjusted to ensure that adequate funds are generated to purchase private health insurance. Federal and state contributions, payroll taxes and premiums can be adjusted for inflation.

* All tax and cost estimates are based on 1990 data.

The state administered insurance fund will be financed from three sources:

- federal and state Medicaid funds currently allocated to children and pregnant women;
- employer payroll taxes; and
- premiums.

Family premiums and cost sharing for some services will be determined by family income.

▶COST SHARING

Cost sharing includes deductibles and coinsurance which is a fixed percentage of the total cost of care. Cost sharing will not apply for preventive care, regardless of income of participants.

Families participating in the SAIFs, with incomes below 133 percent of the federal poverty level, will be exempt from premiums. The annual premium for state-contracted private insurance for a family with income over 200 percent of the federal poverty level will be $458 per family*. Families with incomes between 133 and 200 percent of the poverty level will have their coinsurance and deductibles determined on a sliding scale. Coinsurance for primary/major medical services will be 20 percent, and for extended/major medical (care coordinated) services will be 30 percent for families with incomes above 200 percent of the poverty level. (See table 2.)

Based on national standards, states will determine eligibility for subsidies for state fund participants. Provisions are included for timely review of income status should family income change substantially during the year.

Families whose dependents receive insurance through an employer will pay a $200 deductible. Coinsurance for primary/major medical will be 20 percent and 30 percent for extended/major medical services. (See table 3.)

* All tax and cost estimates are based on 1988 data.

TABLE 3—COST-SHARING STRUCTURE EMPLOYER BASED INSURANCE

Annual Premium Share	Annual Deductible	Coinsurance		
		Category 1: Preventive Benefits	Category 2: Primary/Major Medical Benefits	Category 3: Extended/Major Medical Benefits
Variable Up to 25% of Cost of Plan	$200	No Deductible or Coinsurance Regardless of Income Level	20%	30%

Note: A [illegible] cap of 10% of family income to a maximum of $3,000 per family or $1,000 per beneficiary limits out-of-pocket expenditures.

Total family out-of-pocket expenditures for health care will not exceed 10 percent of income, up to a maximum of $1000 per year for an individual and $3000 per year for a family. This applies to dependents insured through either an employer or the SAIF. Above these amounts, catastrophic coverage will apply for both.

▶ TOTAL COST

The Academy plan will add $12.6 billion to the $98.8 billion spent in 1990 on health services for mothers and children. This amount represents about two percent of all health care expenditures for 1990. The majority of these monies will be generated by the system itself. (See table 4.)

TABLE 4—CHANGE IN SOURCES OF PAYMENT FOR HEALTH CARE UNDER THE AAP PROPOSAL IN 1990 (IN BILLIONS)

Source of Payment	Current System	AAP Plan	Change in Expenditures
Family Out-of-Pocket	$27.5	$15.2	-$12.3
Employer Plans	42.0	57.6	15.6
Non-Group Plans	2.5	0.0	-2.5
Other Private (includes charity care)	4.7	0.9	-3.8
Medicare	0.1	0.1	0.0
Medicaid	15.1	0.0	-15.1
CHAMPUS and Military	2.1	3.1	1.0
Other Public Programs	4.7	0.7	-4.0
State Administered Fund	NA	33.6	33.6
Total	$98.8	$111.4	$12.6

* 1990 Lewin/ICF estimates

AAP Proposal for Universal Access to Health Care for Children and Pregnant Women, April 30, 1990, Prepared by: Lewin/ICF

FREEDOM OF CHOICE

Patients will choose providers and insurance plans that best suit their needs. Physicians will determine their own participation in various insurance plans. Insurance plans will have to include enough services and providers to be attractive to the insured and offer sufficient reimbursement to assure adequate participation by physicians and other providers.

USER FRIENDLY

The Academy's proposal is designed to ensure that decisions about the health care of children and pregnant women will be based on the needs of the patient rather than being driven by the complexities of obtaining financing for that care. Necessary services will be readily accessible without the complex procedural barriers that currently exist. Payment systems and explanations of benefits will be uncomplicated and uniform.

Insurers will be required to develop simple, standardized forms and systems that quickly determine deductibles and coinsurance. For example, a "credit card" system could indicate the patient's share of charges using "on line" connections to insurance company computers.

To help address nonfinancial barriers to health care, states will be required to develop mechanisms to overcome geographic, language, educational, cultural and other roadblocks to health care. Case management of children with special health care needs will help assure that they receive necessary services.

FAIR COMPENSATION

Physicians should be able to devote appropriate time to the diagnosis and management of complex health problems, and they should be reimbursed commensurate with their training, responsibilities and commitment of time. Under the Academy plan, physician reimbursement for services will be determined by the free market system. Provider reimbursement through the SAIF and the employer based system will be comparable because the state and employers will have the same choices of private insurance plans.

COST CONTAINMENT

The Academy plan will control costs by covering only necessary and effective services. Savings will be realized by the widespread utilization of comprehensive preventive health services, simplified billing procedures to reduce administrative costs, and the use of coinsurance and deductibles.

The AAP plan is designed to provide comprehensive, continuous health care. Having patients linked to providers will decrease the need to use the emergency room as a source of primary care. The availability of a constant caregiver will enhance the use of preventive services, such as immunizations, which save ten dollars in health costs for each dollar spent. Such caregivers can frequently provide cost efficient, care coordination for chronically ill patients whose complex needs require careful management.

The cost benefits of prenatal care go far beyond the three dollars saved for each dollar spent. Five hundred dollars spent on prenatal care can save an average of $20-30 thousand on a low birthweight infant who spends a relatively brief time in an intensive care nursery. Costs for longer stays can be staggering. Education and counseling provided to pregnant women may prevent the tragedy as well as the heavy financial burden of babies born with fetal-alcohol syndrome, cocaine addiction and the damaging effects of brain hemorrhage or respiratory distress.

PHYSICIAN COMPENSATION UNDER REVIEW

There are two federal initiatives in which the AAP is involved that should help assure more appropriate reimbursement for physicians. Academy members participated in the development of Harvard's resource-based relative value scale (RBRVS) that is based on time, training and skill with adjustments made for geographical differences in practice costs and medical liability coverage. Federal implementation of the RBRVS will begin with Medicare reimbursement and will be phased in over five years beginning in January 1992. The Physician Payment Review Commission has been required by Congress to "study the adequacy of physician reimbursement under Medicaid." The Academy presented testimony before the Commission with the following recommendations for this report, scheduled for release in July, 1991:

- Create a Medicare RBRVS-based payment system that reflects the health care needs of poor children.
- Conduct a separate Medicaid study of pediatric subspecialty procedures to develop benchmark services.
- Conduct a Medicaid study to determine how to improve rural practice conditions and access.
- Recommend an increase in Medicaid fees for pediatric care to 90% of usual, customary and reasonable (UCR) or equivalent to those in Medicare, until results of the RBRVS study are available.

While these initiatives focus on Medicaid and Medicare, it is anticipated that they will eventually serve as the basis for reform of physician compensation and will be adopted by other payors.

In 1930 the Academy became the first national medical organization to recommend the use of public funds to provide maternal and child welfare aid to those groups unable to pay for medical services. In formal testimony, the Academy admonished the Congress to avail itself of the expert counsel of physicians and professional organizations when drafting legislation affecting the health and welfare of children. These forceful remarks firmly positioned the Academy as a leading voice for children, and established principles which continue to guide the Academy today. For 60 years, pediatricians have fought fiercely to develop and protect programs for children. The Academy has never wavered from the dedication and commitment of its members and staff toward the development of a national policy that places our children first.

Today 40,000 Academy members are working to ensure that children's needs are met at every level. As America moves toward ensuring access to quality health care, the American Academy of Pediatrics offers a plan that assures all children access to the care they need to grow into healthy, productive citizens.

"As the leadership of this great body, we sense an emerging sentiment that it is time to make a promise to our most precious resource. As human beings, children matter in their own right, and as future contributing citizens, leaders, consumers, employers, and taxpayers, they deserve the best that we can offer to them. We must commit ourselves to this end."

[redacted]

For more information on the Academy's federal legislative efforts to assure universal access to health care for all children and pregnant women, or to be put in touch with an access legislative coordinator in your state, contact:

AAP, Department of Government Liaison, 1331 Pennsylvania Avenue, N.W., Suite 721 North, Washington, D.C., 20004, or call 202/662-7460 or 800/336-5475.

It is time for all Americans to demand that their elected representatives honor their commitment to the needs of our children. It is time for the United States to become a nation that makes the health and well-being of its children its highest priority.

ADDITIONAL READING:

The Pepper Commission: U.S. Bipartisan Commission on Comprehensive Health Care. *A Call For Action*. Final Report September 1990, U.S. Government Printing Office, Washington, D.C.

Harvey, B. "Special Report: A Proposal to Provide Health Insurance to All Children and All Pregnant Women." *New England Journal of Medicine*, 1990, 323:1216-1220.

AAP Special Report: Barriers to Care. American Academy of Pediatrics, 1989, Elk Grove Village, IL.

AAP Special Report: Solutions American Academy of Pediatrics, 1990, Elk Grove Village, IL

Senator MIKULSKI. The Committee is adjourned.
[Whereupon, at 4:40 p.m., the committee adjourned.]

O